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VA MEDICAL CONSTRUCTION BUDGET FOR FISCAL YEAR 1987

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ORIGINAL

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

MARCH 6, 1986

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VA MEDICAL CONSTRUCTION BUDGET FOR FISCAL YEAR 1987

THURSDAY, MARCH 6, 1986

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 10:30 a.m., in room 334, Cannon House Office Building, Hon. Lane Evans presiding.

Present: Representatives Evans, Mica, Kaptur, Penny, Rowland of Georgia, McEwen, Smith, Bilirakis, and Rowland of Connecticut.

Mr. EVANS. The hearing will come to order. Congressman Edgar, chairman of the subcommittee, is unavoidably detained. I will be chairing the committee hearing, but I would like to start out by reading his statement.

STATEMENT OF CHAIRMAN EDGAR

The purpose of today's hearing is to receive testimony on the proposed Veterans' Administration medical construction budget for fiscal year 1987. We will also examine the sensational illogic of cropping 41 percent from the fiscal year 1986 construction budget and proposing that very small amount for fiscal year 1987. This is done at a time when the VA is turning away each month over 35,000 eligible veterans needing care, at a time when the impact of the exploding aging veteran population is well documented and is virtually upon us, and at a time when half of the VA medical facilities are over 30-years old.

In the year 2000 when the number of aging veterans will peak these facilities will be nearly half a century old. If we perform no maintenance and improvement, what kind of medical care will we be able to deliver? We want to learn how the selection of the projects in the larger 5-year plan for 1985 through 1989 became the smaller 5-year plan for 1986 through 1990, and finally the very small budget request for fiscal year 1987.

We want to learn what has become of the capital improvement initiative described in the subcommittee last year. The idea of assessing the status of the VA medical facility physical plant is a good one. It will help both the VA and the Congress determine the construction needs of the system.

We want to learn why the budget requests no nursing home projects, especially in areas where there are no alternatives. We want to learn of the planned VA/Air Force sharing agreement at Albuquerque which sounds as if it may be a good way to meet health care needs and save Federal dollars. Indeed the entire VA/DOD health resources sharing act is something we want to encourage.

As the witnesses give their testimony today, let us not forget that the budget proposed by the Administration for fiscal year 1987 is not a result of Gramm-Rudman-Hollings. It is a blueprint for what the administration plans for the VA.

Mr. EVANS. Now I would like to recognize Mr. McEwen, the ranking member of the subcommittee, for his comments.

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Mr. McEWEN. Thank you, Mr. Chairman. I would ask at this point that the remarks of John Hammerschmidt, the ranking member of the subcommittee, be submitted to the record.

Mr. EVANS. Without objection, so ordered.

[The prepared statement of Mr. Hammerschmidt appears on p. 39.]

OPENING STATEMENT OF HON. BOB McEWEN

Mr. McEWEN. Thank you, Mr. Chairman. As you know, our consideration of the proposed medical construction request is very important.

In our review of this construction document we are seeking to find the best way to ensure that our veterans receive adequate health care.

Dr. Ditzler, I have carefully studied your assessment regarding the current and future needs of the VA health care system. Your comments regarding the aging of these medical facilities is a poignant reminder that we must approach the construction budget with prudence and foresight. If we intend to honor our commitment to veterans we must continue to modernize and renovate our facilities. I am strongly committed to this endeavor and want to assure you of my willingness to meet this challenge.

Mr. Chairman, I would be remiss if I did not express my appreciation for the leadership efforts of our colleague from Ohio, Tony Hall. He has provided this subcommittee with the benefit of his experience regarding the pressing needs of the VA Medical Center in Dayton, OH. I want to commend the gentleman for his diligence and commitment to the modernization of this hospital.

Mr. Chairman, as I indicated earlier, we are facing a challenging period. I look forward to working with you and the other members of the committee in maintaining the benefits and services which veterans so strongly desire and need.

Thank you, Mr. Chairman.

Mr. EVANS. Thank you. The first witness is Congressman Tony Hall from Ohio.

Mr. HALL. Thank you, Mr. Chairman, Congressman McEwen and Congressman Smith. I thank you for the chance to be here and testify before you.

I have a prepared statement, and it is a rather lengthy statement. I won't read it, but if you would, I would like for it to be part of the record.

Mr. EVANS. So ordered.

[The prepared statement of Mr. Hall appears on p. 43.]

STATEMENT OF HON. TONY P. HALL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. HALL. I am testifying today in support of the Administration's request for $8.4 million for the design of a new hospital building at the Dayton, OH, Veterans' Administration Medical Center, which is in my district.

On several occasions I have visited Brown Hospital which will be replaced by the new building. I can assure the members of the subcommittee that this building does not meet my standards or any-

body else's standards for what a modern health facility should be, certainly a facility that should be taking care of our veterans.

The current building is unsafe. It is not resistant to earthquakes. It would be difficult to evacuate in case of emergency. It lacks privacy and has several large rooms with 24 beds or more in them.

The intensive care units are not up to current standards. This building serves a primary service area of 28 counties in Ohio and 1 in Indiana in which reside a total of 387,000 veterans. It is also a primary teaching hospital for the Wright State University School of Medicine.

I am not asking for any change or any increase from the President's proposal, and I would hope that this committee would look favorably on this request.

Thank you very much.

Mr. EVANS. Thank you. We appreciate your testimony today.

The VA has in fact requested this amount in its budget, and I am sure this committee will look favorably at the request.

Mr. SMITH of New Jersey. I just want to add my praise to Mr. Hall of Ohio for his leadership on behalf of veterans and in particular on behalf of this hospital and to assure him it has my strongest support, and anything I can do I certainly would do. Keep up the good work

Mr. HALL. Thank you, Congressman.

Mr. MCEWEN. I would like for the budget request from the VA to be submitted following Mr. Hall's testimony which outlines the very significant need that exists here, and extend my commendation as well to the gentleman.

[See p. 45.]

Mr. MCEWEN. I am convinced as a result of his diligence that his friends in the Congress and on this committee will see to it that the design is approved and that we can begin designing this facility in 1987. I thank him for his efforts.

Mr. HALL. Thank you, Mr. Chairman and Congressman Smith and Congressman McEwen, certainly Congressman McEwen for his support on this committee and his great effort that he has put forth on behalf of this hospital.

I thank him and thank you very much.

Mr. EVANS. Thank you for testifying today.

Next is a panel led by Dr. John Ditzler, Chief Medical Director of the VA, accompanied by John Gronvall, Richard Falco, Susan Livingstone, Albert Peter, and Charles Yarbrough.

You may go ahead if you want to summarize. Your statement will be entered in the record in its entirety.

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STATEMENT OF DR. JOHN W. DITZLER, CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION, ACCOMPANIED BY DR. JOHN A. GRONVALL, DEPUTY CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION, RICHARD P. FALCO, ACTING DIRECTOR, FACILITY ENGINEERING, PLANNING AND CONSTRUCTION OFFICE, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION; SUSAN LIVINGSTONE, ASSOCIATE DEPUTY ADMINISTRATOR FOR MANAGEMENT, VETERANS' ADMINISTRATION; CHARLES V. YARBROUGH, DIRECTOR, MANAGEMENT SUPPORT OFFICE, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION

Dr. DITZLER. Thank you, Mr. Chairman. I should introduce first those at the table with me.

To your extreme left, Ms. Susan Livingstone, Associate Deputy Administrator for Management, to my immediate right, Dr. John Gronvall, the Deputy Chief Medical Director; to my immediate left, Charles Yarbrough, who is my head honcho for management, Department of Medicine and Surgery, and to my left is the acting director of FEPAC, which is the Facility, Engineering and Construction Planning Group of DM&S, Mr. Richard Falco.

I should say at the outset that there are several things I would wish to emphasize, knowing that the full statement is submitted to the record. One is that we have a tremendous capital investment, and these buildings are aging. Only 15 percent or better really are modern and 53 percent of our hospital beds are in buildings 30 years or older.

Our construction program, therefore, represents a commitment to the capital investment program, and all told, it is dedicated to meeting the facility needs for a modern health care system.

There is $465 million which covers major projects, minor projects, and many in the maintenance and repair category. The planning process begins in the field with our medical district initiated planning system. I believe this year we have brought to fruition a methodology of struggling with grading the importance of and prioritizing the construction projects.

I think finally I would like to say that we think the proposal that will be before your committee is a way of reorganizing the method by which we go through the entire construction process. We think the proposal has great merit, and we urge your attention to it.

Mr. Chairman, I would like now the opportunity for all of you to quiz all of us, and we stand ready to try to answer your questions.

[The prepared statement of Dr. Ditzler appears on p. 48.]

Mr. EVANS. All right, Doctor, thank you. The construction budget request for fiscal year 1986 was $723 million. This year's request is $408 million.

In Dr. Gronvall's statement to the subcommittee last year he said that the requested funds were needed as, ". . . the commitment to the capital investment program which preserves and protects the capital plant," and "The health care system must respond to the changing needs of the aging veteran population."

When we see that over 50 percent of the facilities are 30 years old and that you are requesting 41 percent less major construction funds than last year, can you tell us what has changed from last

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year to cause this sharp reduction in funds and what is your estimate of the impact of growing obsolesence on your medical infrastructure?

Dr. DITZLER. The significant change I believe is in two categories.

First, I think we have come to better understand how we will attempt to meet the future of the veteran population needing health care which was highly emphasized and widely distributed about 18 months ago in the report on the care of the aging.

We have reassessed the costs of building nursing homes. We have reassessed the impact and the cost/benefit ratio of supporting the veteran State nursing homes, and we have reassessed the fact that modern technology, modern health care, is changing our daily census at a considerably rapid rate. Ten years ago we would have had an average daily census in our hospitals of 75,000 to 80,000. Today we are down to 55,000 plus or minus.

This is indicative of the newer methods of treating patients and acceleration of the turnover and decrease of the lengths of stay. We, therefore, have hospital beds empty that could very well be used in a nursing home-type capacity. It would require some construction efforts, but certainly far less than the cost of building a nursing home.

We also find that the per diem rates for a community nursing home is less than what we generally find in the VA. There are other reasons, but some of the regulations that we are required to observe in the building of a nursing home such as using U.S. steel or all union labor, et cetera, and building for a 50-year period, significantly change the cost as compared to a private nursing home in the community where they look for amortization in 20 years. Because of those reasons, with respect to nursing homes at least, we have taken a different approach.

I think the second major overall reason in answer to your question is that in cognizance of the national deficit, we have simply not included as much in this year's budget.

Mr. EVANS. Well, you are talking again about more of new construction. Specifically, my question concerned maintaining what we already have. Whether we have decline in census or whether this new technology is occurring, my question was more directed at preserving, protecting the capital plant that we already have.

How do you intend to do that with the 41 percent decrease?

Dr. DITZLER. With difficulty, but we have prioritized those that require the most urgent care.

Mr. EVANS. Your statement indicates that you are requesting $4 million for the conversion of existing but vacant hospital beds to nursing home beds.

How many beds are you converting with the $4 million and where will the beds be located and what is the cost per bed for conversion and how does it compare with the costs of a bed in the newly constructed VA hospital?

Dr. DITZLER. Could I ask my colleague to help me?

Ms. LIVINGSTONE. My name is Susan Livingstone. I can answer that in part. The $4 million in the minor construction budget will be funding conversion of acute care beds to nursing home care beds. Two locations have been identified already. Those are Canandaiqua, NY and Miles City, MT, for conversions in terms of 16 beds

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in Miles City converted and 50 beds in Canandaiqua. I believe other sites are under consideration. They have not yet been identified.

It is my understanding conversion costs approximately $23,000 per bed, but it depends on the state of the building and the facility itself.

Dr. DITZLER. My understanding, Mr. Chairman, is that a brand new VA nursing home bed would be considerably in excess of that. Using the Government criteria for construction, it probably would be double or triple that cost.

Mr. EVANS. Is that accurate?

Ms. LIVINGSTONE. It is currently approximately $50,000 per bed for new construction. As you know, during the last few years, we have been taking a number of actions to reduce the cost for nursing home care beds. In new construction, I believe our current estimate is approximately $50,000 per bed.

Mr. EVANS. What is the balance of unobligated funds for major and minor construction for fiscal year 1985 and what is projected for fiscal year 1986 and 1987? Why is it the balance is so large if it is large?

Ms. LIVINGSTONE. Mr. Chairman, our unobligated balance, end of fiscal year 1985, is $1.4 billion, approximately $1.2 billion of that for the major construction account, and $270 million in the minor.

The estimated end of fiscal year 1986 unobligated balance would be $1.03 billion in the major account and $263 million approximately in the minor account. We anticipate that these unobligated balances will be dramatically reduced by the end of fiscal year 1987, going from a $1.3 billion total at the end of fiscal year 1986 to about $580 million total, in both accounts, at the end of fiscal year 1987.

In the major construction account, this is primarily reflective of about 279 projects still in current stages of design or construction. As you know, we have a number of replacement projects in our recent budgets, extremely high-dollar volume projects, and construction awards have not yet been made for them. We anticipate very large construction awards in this year and next which will significantly reduce our unobligated balance.

Mr. EVANS. I will yield now to the ranking member for any questions he may have.

Mr. MCEWEN. Thank you, Mr. Chairman. Dr. Ditzler, this book right here, how many of these do you produce? Do you have any idea?

Dr. DITZLER. I thought I knew the answers to most of the questions you might ask, but I am stymied by that one.

Mr. MCEWEN. Who do they go to? They don't go to members of the committee necessarily, do they?

Dr. DITZLER. I'm drawing a blank. I can furnish that for the record.

Mr. MCEWEN. I would like the record to show that. I would like to see and know whose mailing list I can get on so they can share it with me, but I really think that most of the members would have an interest in it, and I know that you are cutting back on spending and appreciate that, but I think that——

Dr. DITZLER. The distribution is performed by the Controller, Mr. Hoffman. Beyond that, I can't help you, but I will promise to get you the information.

[Subsequently, the Veterans' Administration furnished the following information for the record.]

5-YEAR MEDICAL FACILITY CONSTRUCTION NEEDS ASSESSMENT

The Agency prints 2,000 copies of the Needs Assessment; 20 copies each are provided to the House and Senate Veterans' Affairs Committees and the House and Senate Appropriations Subcommittees for distribution to the Chairmen and Members.

Mr. MCEWEN. The whole committee, the Hospital and Health Care Subcommittee, need to see where you are going to spend your money.

Thank you very much. I have already found a source to borrow it from.

You mentioned that about 1,000 new nursing home care beds were funded in 1985 and 1986.

When will they actually be available for us?

Ms. LIVINGSTONE. Usually it takes approximately 2 years to get a project under construction after it has been funded. The first year is working drawings and then construction, so probably you are looking at 1987 or 1988 for the fiscal 1985 projects and approximately fiscal year 1988 or 1989 for the 1986 projects.

Mr. MCEWEN. Thank you. If the Veterans' Administration somehow had the opportunity for additional nursing homes, where would they be located?

Dr. DITZLER. Well, we indicated that our choice would be Tampa and Hampton which would probably be our first choices.

Mr. MCEWEN. Thank you. If the Veterans' Administration had a study done by consultants that recommended that only part of the Office of Construction be moved to the Department of Medicine and Surgery, why are they proceeding with moving the entire office contrary to the recommendations?

Dr. DITZLER. Congressman, I am not certain that I totally agree that the recommendation of the Booz, Allen, Hamilton report was to move only a part of it. The complete Booz, Allen, Hamilton study, which consumed well over a year's time, essentially specified that the problems related to fragmentation. I believe their final report clearly shows the long term aim is to decrease to a minimum the fragmentation of responsibilities.

The question, therefore, I believe is not whether a part of it was recommended but rather who should assume the final responsibility and where should it rest at that point in time?

There are varying views as to the degree of acceleration to the end point, but I do not believe the Booz, Allen, Hamilton study recommended only a partial solution.

Mr. MCEWEN. Let's assume that nobody said anything. Is that a good thing to do?

Dr. DITZLER. I think it is the only way to resolve the conflicting areas of responsibility. I have no doubt in my mind that the simple sitting down of the group of people with one individual as a final responsible person is the way to make things more effective; providing there is proper oversight into the overall planning process

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and providing there is also an oversight regarding the fiscal obligations.

Mr. McEWEN. Thank you. In the budget request $4 million is for conversion of existing vacant hospitals to nursing home care, and if you have answered this, I apologize, but how many beds do you hope to get from that?

Mr. DITZLER. Dr. John Gronvall can answer that.

Dr. GRONVALL. Mr. McEwen, I might expand a little bit on that question and an earlier one where you asked us to give some statistics and project those out into the future that will portray what will happen to our nursing home beds at the VA based on the budget that is before the committee.

During this current year, 1986, we have two new nursing home care projects which will produce 240 beds. There are four projects under way this year to convert beds in existing hospitals, and there will be about 291 nusing home beds produced as a result of that.

Mr. McEWEN. 291 beds?

Dr. GRONVALL. 291 beds in four projects in four existing medical centers to convert beds to nursing home beds. At the end of this year, fiscal 1986, we will have about 11,412 nursing home beds in the VA. In the 1987 budget that is now before the committee, there are two new construction projects that will have nursing home care beds in them. Those are the projects in Augusta and North Chicago. There are 190 new nursing home care beds in those two projects.

As was mentioned, there are other conversion projects currently identified that will add up to about 66 beds. Other medical centers are being considered for conversion potential using portions of the $4 million of minor construction funds not currently assigned. Those numbers have been extended out through the year. I won't bore you with reading all of the details, but at the end of 1987 we expect to go up from 11,400 to about 12,000. By the end of 1988, we will be at 13,400 beds; by the end of 1989, to 14,400; and by the end of 1991, we will be at about 14,862 beds. So we have a long-term projection for a gradual expansion both through new construction, where nursing home beds would be a part of new construction, and conversion of existing hospital beds. It will go from the current 11,400 to about 14,800.

Mr. McEWEN. I thank you for that response. Am I correct in assuming that the $4 million would give us about 240 new beds this year?

Dr. GRONVALL. The $4 million for bed conversion will be less than 240 beds. We have identified two medical centers which will have a net increase of 66 beds at a cost of $1.9 million. Other medical centers are being identified where bed conversion can be supported with the remaining funds.

Mr. McEWEN. My time is up. Just let me say I very much appreciate what you do for a living. I appreciate the contribution you make and I understand the constraints that you operate under and that many people place parameters on you and you see the need up close as much as anyone, more so than most, and for what you do with the limited resources you have, I thank you very much.

Dr. DITZLER. Thank you.

Mr. EVANS. The gentleman from New Jersey?

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Mr. SMITH of New Jersey. Thank you, Mr. Chairman, and Dr. Ditzler and members of the Veterns' Administration, welcome again to the Committee.

I have an overriding concern about South Jersey's outpatient clinic. Some of you may be aware of it. I have been pressing for this now for 4 years, and as you well know, the 1984 MEDIPP study for Region No. 2 stated that Ocean County had the greatest need for an outpatient clinic, with Borden and Atlantic County coming in a close third.

Some 51,222 service connected visits per year were estimated for the Ocean County clinic, and as you well know, 15,000 visits per year will justify construction of an outpatient clinic according to the VA standard. I was informed informally on September 27, by the Administrator that the clinic was going to be approved at least at Level 1, and additionally on November 12th I was informed that it had indeed been approved at Level No. 1.

I was wondering if you can tell the committee and me at what stage the planning is now internally within the VA for the outpatient clinic, and can we expect approval of the plan this year and do you expect the funding request to be forthcoming in the next fiscal year?

Dr. DITZLER. Mr. Smith, assuming that we can expedite, we would assume that it will be through the Level 2 process which is the formation of the specs for location as well as size, dimension, and that it would come from funding in fiscal 1988 which is the next fiscal year. That is the presumption that I have at the moment.

Mr. SMITH of New Jersey. I appreciate that. Anything you can do in any way to expedite that, would certainly be appreciated. I hope that you put this on a fast track.

I do have a couple of other questions. How well in your opinion, Dr. Ditzler, is the medical program working?

Dr. DITZLER. Considering the size of this task and the magnitude of the considerations that each of our medical centers have, I think the MEDIPP part, that is, the medical districts initiated plan, has done very well.

The reform that needs to be done and has been begun is to integrate that, therefore, at our regional level so that everything doesn't just stop at the facility and then get dumped on the people in the central office which originally was a large part of the process.

I believe we have now resolved that, and our regions are now beginning to actively review the plans.

There is another element of the MEDIPP process that initially had to overcome natural human behavior and that is a wish list. When everyone locally plans what they would like, it may or may not be needed as someone else sees it. I think we have now gotten over that. I think we now have planning in the regions, that it is really getting down to need as opposed to I wish I had so that I think it is maturing well.

We need another year or two before we can feed all construction and all financing and budgets and everything into the same process. For a major government operation, I think it is a superb process.

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Mr. SMITH of New Jersey. One final question—first of all, I want to concur with my friend from Ohio a moment ago in congratulating you for the job you and your staff are doing under very difficult circumstances, particularly during these times of budget constraints.

Can you tell the committee are there any major construction projects that had to be delayed or cancelled because of the budget crunch?

Dr. DITZLER. Yes. We didn't get all we wished, either, so yes, some projects were cancelled.

Mr. SMITH of New Jersey. Okay. Perhaps for the record you could provide some of that information. It would be helpful.

[The information referred to appears on p. 53.]

Mr. EVANS. Thank you. The Chairman recognizes Ms. Marcy Kaptur.

Ms. KAPTUR. Thank you, Mr. Chairman. Welcome, its good to have you back, and under these difficult times in which we are living. Thank you for your service to the country and to veterans.

I wanted to ask you, Dr. Ditzler, in testimony I have heard over and over from different groups, people keep telling us that the VA is turning away each month over 35,000 eligible veterans needing care.

Could you comment on that statement, please?

Dr. DITZLER. I would be happy to. We tried in 1984 to make a 1-week determination of the number of people coming to our hospitals but we simply could not provide what we would like to. It started out as a health service research project. It was repeated with some changes of the definitions of some of the data that was obtained in 1985. We have locations in 1984 showing that we were turning away 25,000 or 30,000 and data now in 1985 suggest we were turning away 30,000 to 35,000 or even more. The problem, in my judgment, is a failure to define in the sharpest terms what it is we were asking and what it was people were recording. Suffice it to say that this project took every single patient applying to a hospital in every one of our facilities nationwide for 1 week and examined those who were accepted versus those who were not accepted for care.

We took care of well over 93 percent of all people who walked in the door. The number who were turned away nationwide in that 1 week, was approximately 8,000 plus or minus 100 or 200. If one multiplies that week on a monthly basis, one does come out with a rough figure of some 30,000. I have to tell you what the survey meant with respect to turned away. For example, we have many patients in the private hospitals today who have run out of money, who have run out of their insurance, and the hospitals are pushing to get them out. If they find they are a veteran, they make a phone call to the VA saying won't you take this patient? Many of them are looking for long-term placements of stroke victims, et cetera.

That one phone call would have accounted for one applicant being turned away, so when one adds up all the phone calls wherever we did not send or transfer a patient from a private hospital, that also counted as a turned-away applicant.

Those individuals who wanted something special who required an unusual procedure such as a total hip replacement would have

been put on a waiting list and, if the waiting list couldn't handle them in 30 days, they were counted as an applicant turned away.

When one scientifically examines the results of this thing, I don't think that we honestly can say how many were turned away as opposed to the common impressions you get. Yes, they did not receive all that they wanted on that day. In some cases there was simply not an empty bed for that kind of patient for that kind of procedure. In some cases there were patients who had been cared for years with say high blood pressure, but there were no more spaces in the hypertension clinic until maybe 2, 3 months down the road, and they would have not been entered on that day.

The definitions are a problem, but I think we can say that there were a considerable number that we did not serve during that 1 week survey.

Ms. KAPTUR. I appreciate that fuller explanation. This is the first time I have really heard anyone go into it.

On a totally different subject, I want to thank you and the people who work at the VA Center in Ann Arbor for the special effort that is now being made to serve our outpatient clinic in the greater Toledo area, and the medical center director there, Mr. Ron Lipp, has really gone the extra mile to work with us. I know you have had some influence in that, and for the first time since that clinic opened in 1979, I think it is getting the kind of attention that is needed and our veterans are extremely grateful for that.

Mr. Chairman, would you grace me with the opportunity to ask one additional question?

Mr. EVANS. Without objection, so ordered.

Ms. KAPTUR. I wanted to ask Dr. Ditzler, in order to conform to the construct of the budget that is being presented, do you have any plans to change the mission of any of your hospitals by closing inpatient facilities?

For example, we have heard that the Walla-Walla Hospital in Washington might be changed to an outpatient clinic.

Would you comment on that trend, please?

Dr. DITZLER. Let me state categorically there are no plans to close any. However, there will be serious mission changes for some of our hospitals. Some of our hospitals that have performed in all branches of medicine, say surgery and psychiatry, will have their missions changed to an extent where they may no longer be providing surgical care. They may be performing primarily as a nursing home and as an outpatient clinic. We do not plan to abandon where we are already located, but there will be mission changes.

Ms. KAPTUR. Thank you. Thank you, Mr. Chairman.

Mr. EVANS. Thank you. Dr. Rowland?

Dr. ROWLAND of Georgia. No questions.

Mr. EVANS. All right. Would you comment specifically on Walla-Walla? We have had a lot of letters on that facility.

Dr. DITZLER. Well, I have listened to discussions about Walla-Walla since I was in Washington 10 years ago. There was always substance for good discussion about Walla-Walla. Some felt they had been funded too well, while others felt they were woefully inadequately funded. So it has always been an interesting topic.

I think the fundamental fact is that under the budget constraints, we are going to have to reform what the mission of that

hospital is. My own judgment is that it probably would do well in some major outpatient function as well as nursing home function. It would also have the ability to refer many of its patients for the more complex procedures to Portland or Spokane and/or other areas.

I can get you more detailed information, but I don't personally have it at the time.

[The referred to information appears on p. 54.]

Mr. EVANS. If you can submit that for the record we would appreciate it.

I would like to go back to the conversion. Exactly how many new beds would you get by conversion with the $4 million?

Mr. FALCO. We have identified two medical centers where there will be a net gain of 66 beds at a cost of $1.9 million. We are in the process of identifying other medical centers to be supported with the remaining funds.

Mr. EVANS. What is the status of your negotiations with the San Francisco Golden Gate National Recreation Authority for use of their land for parking facilities during the construction of the nursing home project and have you had any success in obtaining approval of preparations of the committee to use impact funds for construction in the San Francisco parking facility?

Dr. DITZLER. I will make a general statement and then I will ask Ms. Livingstone to respond.

I think we are, stymied on San Francisco to a point where I am considering recommending withdrawing the building of the nursing home, which is catastrophic in many ways, but frankly we have not resolved the issue.

The issue is not solely related to the parking lot if you will or its pavement. It is simply related to the fact that we have a urgent need to establish parking structures where the geography of the land will not permit us to do otherwise. There is simply no way of continuing the building of the nursing home along with the other high tech facilities that are produced with a great admiration and pride in San Francisco unless we solve the parking solution. We have not.

Mr. EVANS. I yield to the gentleman.

Mr. MCEWEN. Dr. Ditzler, who is the main source of the problem in this effort? Is it the National Park Service?

Dr. DITZLER. The main problem rests between several committees of the Congress I think is the fairest answer I can give you.

The National Park Service has very clearly said they are not going to give any permanency to that land. It's a question of time when they will close their doors entirely to us, so therefore, the solution rests within various committees of the Congress.

Mr. MCEWEN. Are you saying that we need to override the National Park Service's decision? Did I understand that right?

Dr. DITZLER. Well, that's only part of it. The original proposal was that we build a parking garage at San Francisco. One of the committees of Congress took exception to that on the grounds that a parking structure would save $8 million if not built and that we could park our cars over on the adjacent hill of the national park.

Well, it is really not the National Park Service. It is the Park Service that relates to that area.

Mr. McEWEN. Okay. Who made that decision?

Dr. DITZLER. That was done in the appropriation process where the monies could not be obligated for the construction procedure until we achieved an alternative approach. We have failed over the last 2 years to get the Park Service to agree that they will allow us to do this other than on the temporary 3-year basis, and so we are still in limbo on the whole process.

Mr. McEWEN. I'm sorry. I just sounds to me like this ought to be resolved.

Dr. DITZLER. I agree.

Mr. McEWEN. So we need to go back to the Subcommittee on Appropriations. Ms. Livingstone seems anxious to jump into this.

Ms. LIVINGSTONE. I'm not sure I would characterize it as anxious, Mr. McEwen. This has been a very confusing and very difficult process in terms of the San Francisco project. As you know, the Congress did fund it back in 1984 but there was a specific provision that the VA could not move forward with the parking structure portion of that project without the approval of the Committees on Appropriations. The simple fact is we have never received approval from both committees for a specific parking action in San Francisco.

In the meantime we have vigorously attempted negotiations and have met numerous times with the National Park Service to try to obtain either short-term or long-term resolution of our parking needs on the Golden Gate National Recreation Area. Those meetings have resulted in the position that the National Park Service will renew our lease that we currently have which expires this April 30th for 5 years and no more. It will be a non-renewable lease, but they have a number of conditions they would like to place on it. We have not yet been able to meet those conditions, one of which is the VA will have a commitment to build a parking structure during that time because they have their own legislative mandate which is to preserve those lands for recreational use. They are facing their own difficulties in that regard.

Mr. McEWEN. I would just offer my assistance. I would be more than glad. The Director of the Park Service is from California. I would like to see it resolved in an expeditious manner if he can do that.

Thank you, Mr. Chairman.

Mr. EVANS. Thank you. I have several more questions I would still like to ask, but let me yield to Mr. Rowland.

Mr. ROWLAND of Connecticut. No questions.

Dr. ROWLAND of Georgia. Mr. Chairman, might I ask a question? In your statement you say, "Our budget request reflects a policy of meeting veterans nursing home care needs primarily through the conversion of underutilized hospital beds in the medical centers and a greater use of community and State facilities."

What alternatives are you looking for, for taking care of those veterans who need medical treatment aside from this since there is a reduction in the amount of construction that you are going to be doing from here on?

Dr. DITZLER. We have clearly moved ahead on hospital-based home care as well as evaluation of the effectiveness of health care centers. One of which is in the private sector under a contract, and

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it compares the cost effectiveness of hospital-based home care being done by contract as opposed to being done only by VA.

We are looking further into more so-called halfway or quarterway houses not only for those with alcohol and drug problems, but also for the psychiatric patients. I believe those provide the alternatives other than nursing homes or hospitals, and clearly the increased activity in the satellite outpatient clinic has shown that by care in the satellite clinics we can also help solve the problem.

We have just completed part 1 of a congressionally mandated study on rural health care, and interestingly enough, we found that 97 percent of all veterans in this country are within 100 miles of a VA facility. I think it is clear that for that 3 percent that don't live within 100 miles, we are going to have to go in for some other mode of care, either one physician type triaging of some patients in the rural areas or perhaps even going contract to the private sector which would be more cost-effective.

Dr. ROWLAND of Georgia. Are you exploring then home health care maybe on a contract basis? And what about hospice care for veterans in the private sector?

Dr. DITZLER. We had an experimental unit, I should say a research-oriented hospice unit in the VA medical center at West Los Angeles for some 3 or 4 years. It is quite clear that like many of the home health alternatives which I think in the private sector is spoken to as channeling, it is clear that patients get better overall care and better services but it is not cost effective.

Now I do not see us officially creating more hospices in the VA. However, we already have, 20 or 30 of our hospitals that have done it on their own anyway, so I think that the real questions legislatively may relate to respite care as a part of home health care packages because if we get the home health providers, somewhere along the line, we are going to have to provide relief either for the provider or for the patient himself. I think we need to get into respite care more as well.

Dr. ROWLAND of Georgia. I was thinking more about hospice care outside of the VA in the private sector. The hospice has many communities now around the country.

Are you looking into that particular area this morning?

Dr. DITZLER. Well, I don't know whether we would have legislative authority at the moment to do hospice care in the private sector. I think with further evaluation, most of our hospitals are already doing it in-house. The one thing that relates to hospice care, although not normally spoken of, is respite care because many of the patients who are terminally ill can get along very well one way or another if there is some respite possibility. It is interesting that we are providing respite, or the possibility of respite for a spouse who is not a veteran, and that gets into the legal question.

Dr. ROWLAND of Georgia. I think that we need to look at new and different, innovative ways. Probably medicine is going in a different direction now, and I commend you for what you are doing, looking at these areas as possibilities, at the same time reflecting the autonomy of the Veterans' Administration, and I think we may get to that point somewhere. It might be on the end. I don't want to see us do anything that will damage our VA hospital system on the one hand, but on the other hand it seems to me we need to be

looking into other areas about how to provide care on a cost-effective basis.

Dr. DITZLER. Mr. Rowland, I recently attended a House of Delegates meeting of the American Medical Association and we sat and discussed the concern of the physicians relative to the abandonment of the usual physician supervising role in home health care within the private sector now that everybody is getting into the act in home health care. One of the concerns they had was that you can have too much home health care effort if it is not being supervised by a physician supervisor. I certainly think that that is the one area in the VA that we have the opportunity of guiding where that consideration will go.

Dr. ROWLAND of Georgia. I think that is exactly right. You get carried away with something. We did with nursing homes. At one time we had too many nursing homes built and it wound up costing the Government a lot of money, but thank you for your comment.

Thank you, Mr. Chairman.

Mr. EVANS. What is the status of the San Juan, PR, nursing home care unit project we authorized in fiscal year 1985 and when do you estimate it will be completed?

Ms. LIVINGSTONE. Mr. Chairman, the nursing home care unit and also the 10-bed rehabilitation unit attached to that at San Juan should start construction this September, and that would be completed about 2 years later, approximately late 1988.

Mr. EVANS. Are you still planning to request design and modernization funds for the San Juan Medical Center in fiscal year 1988?

Ms. LIVINGSTONE. Last August we sent a letter to Congress requesting approval to add the San Juan modernization project into our advance planning fund listing, and approval has not yet been achieved. We may now request approval to add the San Juan project to our fiscal year 1986 advance planning fund list.

Mr. EVANS. When it was recognized there are no State veteran home beds and a shortage of community nursing home and acute care beds in Florida, why didn't you request funds for the Tampa nursing home project as well as the Palm Beach Hospital in which you are incurring a 5-year plan and were scheduled for fiscal year 1987?

Dr. DITZLER. Mr. Chairman, we did present that as part of our needs assessment and it did not survive the budget process. We appealed it, but because of the constraints on the budget we lost our appeal.

Mr. EVANS. What is the status of your program to implement a facility strategic planning process? How many facilities have gone through this process? How long will it take to complete the process for the entire hospital system, and what is the status of the capital facility study?

Dr. DITZLER. I will let the last one for Ms. Livingstone. The remainder I will address.

I would argue, and I suspect many of the directors in the field would argue, that we already have a facility planning process. The directors are able to combine that process with the MEDIPP process and determine what they physically need in their structure, whether they need a nursing home or whether they need to move something somewhere else. As a part of that process, the engineers

of the facility and occasionally even local architect consultants are used in defining how extensive the plans will be and how it will work in the future.

The Booz, Allen, Hamilton report essentially suggested that, if we use better upfront planning in the engineering and architectural efforts, we would end up with a faster track in construction and a better design and with fewer changes, and I think they are absolutely right.

We have in fact asked for some $5 million for the purpose of getting this off and running.

I think it is already being done in some fashion, but not to the degree that Booz, Allen, Hamilton was projecting, that we need to go, and I would agree with that. The real issue is to tie MEDIPP in to the planning process for construction projects and end up with an architecturally sound plan.

That's the purpose for the request. I think the implementation of how we will do this on a nationwide basis is not fully formed, but I would think we could enter planning data on perhaps 30 or 40 of our facilities in this fashion within the next year.

Ms. Livingstone perhaps has an additional answer to that on capital facility studies.

Ms. LIVINGSTONE. Mr. Chairman, in terms of the capital facility study, we are near completion on those 131 medical centers which have architect/engineers on site to perform a survey of the physical plant condition of the entire facility. We should have data computerized on approximately half of those medical centers by the end of this month. The entire process should be completed by August, so we will have all our planning data in the computer at that point.

Mr. EVANS. How many facilities have been involved in that process so far?

Ms. LIVINGSTONE. In the capital facility study, it was 131. I think the previous number we had given was 132, but that counted two divisions of one medical center as separate, so it is really a total of 131 just by medical centers. This would be a very good complement to the facility development plans that were recommended by Booz, Allen, Hamilton in their study of the construction process, and as Dr. Ditzler said, we have requested funding from you in fiscal 1987 to initiate the facility development plan process for our medical centers.

Mr. EVANS. What plans are being considered to share medical facilities with the Department of Defense under Public Law 97-174, the VA/DOD sharing act?

Dr. DITZLER. Yes, Mr. Chairman, I think I can address that.

We found it advantageous in Alaska some time ago to develop a sharing arrangement with Elmendorf Air Force Base. It was a rather unique arrangement in which the VA has no clinic present and really has no hospital present, but on the other hand, the regional office had an evaluation group. Then they developed an alcohol treatment program, and the VA hired a couple of physicians and it ended up that they were put on the staff of the Air Force with full credentials and privileges at Elmendorf Air Force Base. This involved into prescriptions and now Elmendorf has taken over the pharmacy activities of much of the mail-out provisions of

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Alaska. This was one of the earlier beginnings of our relationship with the Air Force.

It is now expanding. I think we have a physician now also in Bassett, WI, at the Army hospital, and in Fairbanks, as I remember.

We have also had a long-standing relationship with Triprer in Hawaii. We have some 40 beds in the Triprer hospital. In their expansion and construction of facilities at Triprer they are going to be abandoning that building. It will contain approximately 130 to 160 beds, and the VA is planning to modernize it for nursing home beds and for psychiatry. That is only part of our responsibility in the Pacific because we have an active sharing arrangement with the Navy on Guam for the care of veterans in that area.

We also have an arrangement with the Philippine veteran hospital system.

This has led us to go further into it, and when we got to developing an outpatient clinic many years ago at Henderson, NV, it was so overwhelmed by the number of veterans that we then moved it into the Las Vegas-Los Angeles outpatient clinic which now is a tremendous, success. They have nowhere to send any of their coronaries or other medical problems except to the local hospital which is fabulously expensive.

In the same town is Nellis Air Force Base and we have negotiated now with Nellis. The Air Force is building an extension to their hospital and we have contracted with them to pay for their building, about 50 beds with the Air Force at Nellis, so we will end up with a jointly financed group of beds and probably with the Air Force doing the staffing.

Just recently I came back from Albuquerque where Kirkland Air Force Base has a major problem. It has to literally replace its hospital because it has failed all the Joint Commission on Accreditation Standards. It simply doesn't meet the physical requirements of a modern hospital. I have negotiated an agreement with General Chessney of the Air Force wherein we will proceed with an arrangement whereby they will eventually close their hospital and not build a new hospital. We will lease out our top floor, our newly-constructed replacement facility in Albuquerque, and I think that we have now worked out the arrangement of staff and coverage.

The tough issue becomes the one related to the dependents.

Mr. EVANS. Doctor, Mr. McEwen has to leave and he has a comment or a question.

Mr. MCEWEN. Do you have a similar arrangement with Tyndell in the Panhandle of Florida, Tyndell Air Force Base?

Dr. DITZLER. I would have to furnish that for the record. I think if memory serves me correctly we do have an agreement with them on radiation therapy and on X-ray.

[Subsequently, the Veterans' Administration furnished the following information for the record.]

There are no VA/DoD sharing agreements between Tyndell Air Force Base and any VAMCs. There are no VAMCs within 50 miles of Tyndell.

Mr. MCEWEN. Okay. Mr. Chairman, I do have to leave. We are going to have some excellent testimony from Bob Moran and Dave Gorman and others, John Sommer from Ohio, but there is a state-

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ment made in the AMVETS' testimony by David Passamaneck that I just wanted to acknowledge and make note of.

It says, "The President has rightfully and courageously advocated the continued recovery of our defense capability, tragically weakened in the wake of the shameful sell-out of our ally and over 58,000 of our fighting men and women in Vietnam."

As someone who has listened to the rewriting of history in the national media, it is as though the United States lost the effort in Vietnam when in actuality it was the action of the Congress in 1975, 2 years after the Peace Agreement had been made. Every American battle had been successful in Vietnam. The people of South Vietnam could be free just as the people of South Korea are free had the Congress continued its honoring of those agreements.

That truth and that statement made by the testimony this morning is something I wish to underline and I think needs to continue to be repeated because it is the actuality of what happened. It is the true mystery, and our young people are getting an inverted, distorted understanding of what happened in 1975 vis-a-vis our allies and the freedom that was lost in Southeast Asia.

Thank you, Mr. Chairman.

Mr. EVANS. Doctor, we interrupted you. Would you like to continue?

Dr. DITZLER. I think I was in Albuquerque.

Mr. EVANS. Okay.

Mr. ROWLAND of Georgia. Mr. Chairman, will you yield for a moment?

Mr. EVANS. I yield to Mr. Rowland.

Mr. ROWLAND of Georgia. I am pleased to hear the working relationship is developing in DOD via sharing.

Let me ask you about Georgia and Eisenhower Fort Gordon, if you are familiar at all with that? My understanding is that they are grossly understaffed at Eisenhower Fort Gordon, but being a hospital downtown or I believe you referred to it as an uptown hospital, that has a medical college there, they have more than adequate number of personnel particularly in the nursing area, and are you familiar with that at all or are you looking into the possibility of any sharing there?

Dr. DITZLER. Mr. Rowland, I believe that they already have several sharing agreements, one of which relates to the cardiac surgery. I can say in general rather than specifically to Augusta and Eisenhower that in the last year we have jumped from perhaps agreements in the numbers of fifties to sixties, to well over several hundred. The number of agreements that we worked out in sharing now is multiplying.

One of the great problems that we have and I think will have to be solved by legislation is to decide how we are going to help the dependents. That is an issue that is discussed every time we talk about sharing.

Now in Albuquerque, for example, the answer is going to be that the Air Force is going to supply their own staff in a VA hospital to take care of the dependents so that we will not be violating any laws.

Now I don't know the specifics of Augusta and Eisenhower, but I suspect that is part of the problem. I will look into it and let you know, sir.

[Subsequently, the Veterans' Administration furnished the following information for the record.]

Eisenhower Army Hospital and the Augusta, GA, VAMC share inpatient and outpatient services on a wide basis. Both hospitals are pleased with the results.

Augusta VAMC has agreed to handle 30 military open heart surgery cases a year. Augusta is willing to increase the number of open heart surgery patients treated provided adequate reimbursement is given.

Dr. ROWLAND of Georgia. I think that is part of the problem. I have heard from retirees who usually go to Eisenhower to get their treatment they are not being provided help because of inadequate personnel at that hospital.

Thank you, Mr. Chairman.

Mr. EVANS. The Chair would yield to the gentleman from Connecticut.

Mr. ROWLAND of Connecticut. Doctor, in your testimony you make mention of the replacement and modernization projects in Georgia and Illinois, providing about 190 new nursing home beds.

Then you also indicate that with the major construction projects funded in 1985 and 1986 you will be adding approximately, well, it looks like 1,090 new nursing home beds.

Are those all conversions?

Dr. DITZLER. No, they are not. There were a number of new nursing homes funded in the past that haven't even broken ground yet, so when we are looking at the number of beds that will be activated this or next year, 1988, et cetera, many of those have been funded by prior fiscal years.

Dr. GRONVALL. To give a specific answer for the 1985 budget, we had nine projects of new nursing home construction. Those nine projects added up to 1,077 beds.

In 1986 we planned to do only two new projects that will result in 240 beds, but four conversion projects. That will add 291 nursing home beds from the 1986 projects.

Mr. ROWLAND of Connecticut. The vast majority are new beds being brought on line versus conversions?

Dr. DITZLER. At the moment, that's correct.

Mr. ROWLAND of Connecticut. Do these meet the needs at this point in time?

Dr. DITZLER. Well, part of the solution to that is getting back again to the question of further evaluation of the aging. If one takes the baseline concerns that we had 18 months ago, the aging American is now really beginning to boom so that, as we look to 1990, there will be a considerable number of aging veterans.

The problem is that I think that many of us have neglected to consider what it is the aging veteran is going to require. That we know. What we don't know is how often is he going to need it, and how many of them will be in the list of priority eligibles? Part of that relates to legislation, so the answer to the question is we probably will have enough nursing home beds because I think we would be wrong to overbuild nursing homes not only autonomously, but we end up becoming a warehousing system.

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If there is any one thing that I saw as a child growing up, it was the warehouses of old soldiers homes that suddenly became a modern hospital system after World War II, so while I want to take care of the old folks and while we need nursing homes, I don't want a warehouse. There are other options for caring for our people.

Mr. ROWLAND of Connecticut. Doctor, just another quick question or two—the American Legion in its written testimony stated that Providence, RI, is in need of a nursing home.

Do you agree?

Dr. DITZLER. Well, they have said that for several years. They certainly have every right to express that view.

Our MEDIPP process, however, has disagreed with them 2 or 3 years running, and I simply have to respect their wishes to say so, but our MEDIPP process would deny that.

Mr. ROWLAND of Connecticut. Is the VA exploring ways of reducing construction costs for hospitals such as standard designs and modular units?

Dr. DITZLER. Well, I think we have always been interested in reducing costs. On the other hand, we are not likely to shrink the effort to produce a quality product, particularly when we build one that we think is going to last 30 to 50 years. I would have to say we are using every modern technique known to man to try and reduce costs but not to reduce the technical requirements.

Mr. ROWLAND of Connecticut. Thank you, Doctor. Any other comments?

Thank you, Mr. Chairman.

Mr. EVANS. Doctor, I know we have interrupted you several times in the middle of the answer, but I do have some colleagues with questions. If you could, quickly summarize the other points regarding DOD/VA sharing.

Dr. DITZLER. Well, I think the Albuquerque one is novel in one respect. In Elmendorf we are dependent in large measure on a sharing arrangement with the Air Force. In the area of Las Vegas, we are becoming co-equals, although we are still dependent on the Air Force. We have the first-time goal and opportunity in Albuquerque in which the VA provides the solution to the Air Force problems and I urge your support.

Mr. EVANS. At this time I yield to the gentleman from Minnesota.

Mr. PENNY. Good morning, Dr. Ditzler. I think I asked in a previous hearing what your future plans were for Building 43 at Fort Snelling when the new hospital is completed.

How far down the pike are you in determining what uses that building will be put toward to fill the entire facility, other uses once the patients move to the new hospital?

Dr. DITZLER. I can bring you the latest discussion of 2 days ago in the House Appropriations Committee where——

Mr. PENNY. Mr. Sabo raised the same issue?

Dr. DITZLER [continuing]. Your colleague asked us to go back to the drawing board and look at the method chosen and options still open to the merging of the insurance center and data center for Building 43. At the moment our decision is on hold on that point.

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Mr. PENNY. We are certainly interested in that being considered as an option.

Ms. LIVINGSTONE. One of the functions that is under consideration for Building 43, and, obviously this depends on the cost of renovation and project size, would be co-location of the Department of Veterans' Benefits regional office into that building.

Mr. PENNY. We are hoping for indeed some use of that building for other veterans' programs that are now housed elsewhere and renting space elsewhere, so we clearly want to keep those possible uses in mind as we move forward with the planning.

I have a couple of questions for another region of the country—the northeast.

Doctor, why were the Pittsburgh and Aspinwall replacement projects not included in this request when it was scheduled in your 5-year plan to be included in this fiscal 1987 budget?

Dr. DITZLER. If memory serves me, we did request that, but it didn't make the budget.

Mr. PENNY. It was requested but it didn't, it didn't stack high enough on the priority list to make the cutoff?

Dr. DITZLER. It was high on our priority list and we requested it, but the total funds available for the budget excluded it. We appealed the item, but it didn't make it.

Mr. PENNY. So you did go through a special effort from your perspective to try and get that included. And at what level was the judgment made to——

Dr. DITZLER. The appeal was made to higher than the Administrator.

Mr. PENNY. Somewhere else along the line in the Administration they said the funding level here requires that the line be drawn in such a way that project doesn't get a response?

Dr. DITZLER. That is my understanding.

Mr. PENNY. Now did they honor the priority for planning funds that you put in the budget and just draw the line at a level that excluded this particular project, or did they reorder both?

Dr. DITZLER. I think I should offer the observation that in our priority planning system we reserve only to the Chief Medical Director and finally to the Administrator the option of deciding what is our priority system. The executive of the agency believes he has the final responsibility to name what he thinks is best.

Mr. PENNY. But in this case——

Dr. DITZLER. I couldn't answer that. I know that from my point of view we had it on our priority list.

Mr. PENNY. Would it have been high on the priority list, that had they just gone down the list you submitted it would be funded?

Dr. DITZLER. I can't answer that.

Ms. LIVINGSTONE. Congressman Penny, the four replacement and modernization projects that do appear in the VA's fiscal 1987 budget request were ranked of higher priority than the Pittsburgh project by our own prioritization system.

Mr. PENNY. Okay—Pittsburgh?

Ms. LIVINGSTONE. Pittsburgh also was a very high priority. However, in this extreme budget environment, not all needs will be met.

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Mr. PENNY. Again, at least that clarifies the point that I was trying to get at, and that is whether your prioritization was honored by the folks higher up the line.

I assume that you also used your new prioritization model to rank construction projects, that in other areas, I think this one replacement medical center, there is a project that is on your list—the Research and Education Center at White River Junction, VT.

Dr. DITZLER. That's correct.

Mr. PENNY. Was your prioritization honored in terms of where they drew the line for that kind of project? I guess I am assuming that is a different category and the allotment here is separate. The amount that might have been allotted here is a separate amount that might have been allotted for the medical center.

Is it a separate pool of dollars that you allocate for different phase of construction project, or does this end up in the same priority?

Dr. DITZLER. The best way I can handle that is to tell it the way I know it to be, and that is we had requested a number of items. In fact, there were at least 18 items more than what eventually made the list.

Mr. PENNY. This one did. Was it on your prioritization model or in your prioritization list? Was it one that would have been——

Dr. DITZLER. That's correct.

Mr. PENNY [continuing]. High enough on the list that they didn't bump it up in a way to clear it, thereby bumping somebody else down, did it?

Dr. DITZLER. I don't mean to be evasive, but I know that we requested a lot of things based on our best judgment of the needs and that essentially reflects a priority, but it just did not make the total budget.

I think if I were to point out that a year ago and 2 years ago, we were funded at almost double the current level, it is obvious that there was a constraint on the budget.

Mr. PENNY. Something has to give. We understand that, when you are told to take 40 percent out of your construction budget, but what I am trying to get at is whether the model that you used to prioritize projects is honored farther up the line.

In other words, if you say these are the first ones to go given limited dollars, is that prioritization being honored along the line or is somebody, is somebody juggling that priority list?

Dr. DITZLER. In general, I would say it has been honored. We would have liked to have gotten Huntington on the list, but the crisis with respect to electric, oil and fire and safety deficiencies at Waco, for example, after the budget passback forced us to reconsider priorities as late as a couple of weeks before the budget was printed. We had to insert those urgent things that had occurred since the budget process had begun, which is why you see Waco in preference to something else.

Mr. PENNY. Thank you. I guess my time is up.

Mr. EVANS. I recognize the gentleman from Florida.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I apologize for my tardiness. I know what it's like. I have a very short opening statement, sir, that I would ask unanimous consent be inserted in the record.

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[The prepared statement of Hon. Michael Bilirakis appears on p. 57.]

Mr. BILIRAKIS. I am concerned as the rest of the committee is and I certainly endorse the committee's recommendations as far as improvements in a budget is concerned. I am also concerned about all areas, but I am going to be provincial this morning if I may, Doctor. This is one of the prerogatives with having lobbied to be on this committee, to take care of your own people first in a sense.

Sir, on page four of your statement you discuss the new methodology for prioritizing construction projects. I won't take time to ask you to go into detail as to what that consists of, but obviously in answering my subsequent questions you will have to go to some detail as far as this area goes.

The proposed clinical addition SCI unit in Tampa for James Haley Medical Center, was slated to receive initial design funds in fiscal year 1987 according to the 1985 through 1989 5-year assessment.

As I understand it, the project for the clinical addition has been combined, actually I guess I should say, with the spinal cord injury addition project because it was considered to be more effective for these two projects to be developed together.

In the 1986 through 1990 assessment, however, the project has slipped to the 1990 budget for initial funding. My concern is, of course, why the slippage? I am going to go into specific questions toward that end, but I am also concerned that as a result of apparently new changes, new allocations as far as the SCI unit itself is concerned, the clinical addition is also slipping. Apparently it is designed to correct space deficiencies in virtually every medical specialty.

It really hurts their effort tremendously as a result of that. I am concerned about SCI also. I guess my first question is why was this position on the VA's priority list changed?

Dr. DITZLER. I think the best way I can answer that is if memory serves, last year this Committee expressed an interest in an academic affiliation with Batemans. That has been a part of the evaluation process. I expect within 2 or 3 weeks we will have a formal report to you on that process. We have been looking at that very assiduously since last August, and most of us have been there looking at it. We have had the Association of American Medical Colleges and everyone else looking at it.

Mr. BILIRAKIS. That's good news, by the way. Thank you.

Dr. DITZLER. We had several interesting problems develop and I think it is fair to say that the paralyzed veterans group located in the Tampa area did not see eye-to-eye with this national PVA group.

As of a few weeks ago, however, they are all seeing eye-to-eye on the subject, but that has taken a bit of time.

Mr. BILIRAKIS. They are seeing eye-to-eye?

Dr. DITZLER. I have a letter from the Tampa paralyzed veterans group that they are now a hundred percent in agreement with the national organization, that's correct.

Mr. BILIRAKIS. The national organization requested you to make changes in the allocations in Tampa and in Gainesville, is that correct? And that then was a factor in the gaining of an agreement?

Dr. DITZLER. That's a part of the factor. The big issue was that they wanted to go from 40 beds to 100 spinal cord injury beds at Tampa, and some of us felt this was a bit excessive. What we really needed to look at was where the best spinal cord acute injury could be treated, where was the best long-term care. We think we have that all resolved.

A related issue was the purchase of land. Originally the VA thought enough land was available. It turns out it wasn't. I believe a parcel of land is now in the hands of the Florida State officials to complete the land surrender which is required to build the spinal cord injury unit and the combined clinical structure.

Mr. BILIRAKIS. My 5 minutes can't hardly be up, is it, Mr. Chairman?

Mr. EVANS. Well, since I have taken more than 5 minutes I will be glad to let you continue.

Mr. BILIRAKIS. Thank you. Doctor?

Dr. DITZLER. The schedule has slipped, but I think that we are back on track now since we have agreement that we will not build 100 spinal cord beds at Tampa but rather 70 or 80, and we will put 30 beds at Gainesville. There is still a resolution of the support from the university, but that cannot impede the construction process of the clinical addition.

Mr. BILIRAKIS. So we are back on track as far as fiscal year 1987 is concerned?

Dr. DITZLER. I will defer to my colleague here.

Mr. FALCO. No, I think that aspect has been resolved, however, we talked about prioritization a little while ago and, based on prioritization of projects in the clinical category, Tampa turned out to be of a lower order of priority than some of the other ones. Of course, it is impacted by the fact that our future resource projections have been reduced.

Mr. BILIRAKIS. Well, all right, but the 1986 through 1995 year assessment states this project was reviewed over the past year which is basically I guess what you are telling us. It was refined which resulted in an increased estimate of cost from $43 million to some $99.5 million.

Now this says the review proved the needs of that area are even greater than anticipated. Has the project been expanded? Apparently not. If anything, apparently it is being reduced from 100 or so beds down to 70 or 80. We are very grateful for that if we can get them quickly. If the needs are even greater than originally thought because we are talking about better than double the cost, how can we justify delaying the project, sir?

Mr. FALCO. Well, I think all that is true, but when you look at the budget environment I think the logic goes the other way. I think that everyone agrees with your statement that the need is there and the project is required. The question is, if the VA projections are going to show levels of construction that we are presently showing, then many, many projects that are of a high order of priority are going to have to be delayed.

Mr. BILIRAKIS. What you are saying is the delay is not related in any way whatsoever to the reallocation of beds to so many to Gainesville and a lesser number to Tampa than was originally allo-

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cated? It is not related to that? It is related to what, budgetary problems?

Mr. FALCO. I think the combination, but if I had to say which was the greater influencing factor, it would be the budget environment.

Mr. BILIRAKIS. In the budget environment, when do we anticipate the construction of the 30 for Gainesville? Are they in the 1990 timeframe also?

Dr. DITZLER. I don't think that is really a related issue to Tampa because I think that will simply expedite Tampa.

Mr. BILIRAKIS. My concern, Doctor, with all due respect, is that we are talking fiscal year 1987 for possibly 100 beds at Tampa and now we have had a slippage in Tampa, some of the reasons apparently resulting from the reallocation to Gainesville, and PVA's request and what not—I say apparently. I don't know, but apparently Gainesville is not going to get their beds for a while and Tampa is not going to get their beds for a while so they are both left out in the cold in the immediate future.

Dr. DITZLER. The issue of Gainesville beds I really don't think is connected. The issue is how do we provide the quality of care that is needed for the spinal cord injury patients, and I think we are now all agreed that it would have been too many beds for one hospital to handled. I think the issue is not in any way related to Gainesville getting the spinal cord beds.

Mr. BILIRAKIS. Just one final question—I appreciate the chairman's tolerance.

Is there any chance that we may take another look at the overall picture and at least slide the clinical addition from the SCI—and I am not belittling the significance of the SCI. Please don't take it that way, but if we are going to have to face the delay as far as that goes, should we have a delay or must we have the delay as far as clinical additional is concerned which is so desperately needed?

Dr. DITZLER. I think Mr. Falco's answer is probably the one that is closest to the real answer, sir. You may recall that last year Mr. Walters referred to some of the budgetary figures as plugged. I was not too sure what that meant when he said it, but I think I know now.

What it means is that as we develop a needs assessment and prioritize the needs, we see perhaps an expenditure on any given year let us say of seven hundred million dollars minimal.

However, if one looks at the budget outyear projections for the Veterans' Administration, published through 1990, the published outyear projections for the VA don't match in any way what we saw a year ago as our prioritized list.

Mr. BILIRAKIS. Now your prioritized list is based in part on apparently the President's budget request or budget recommendations?

Dr. DITZLER. Our prioritized list is based in part on what we think we need.

Mr. BILIRAKIS. On what you think you need?

Dr. DITZLER. That's correct. However, as of this last year we are now having to cut off a portion of what we think we need because of the outyear projections.

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Mr. BILIRAKIS. If the record of the strong recommendations on the part of this committee to the whole Congress is met in terms of putting dollars back in, is there a chance that the VA will take another look at this picture?

Dr. DITZLER. I would be happy to.

Mr. BILIRAKIS. Your answer is yes?

Dr. DITZLER. Yes.

Mr. BILIRAKIS. Who should—Dr. Gronvall, it's just always great to see you, sir.

Dr. GRONVALL. I like money, too. That's why I was smiling.

Mr. BILIRAKIS. All right, but I would like to be in constant touch with someone in the VA on this particular issue. Who is the man there? Man or woman I should say.

Dr. DITZLER. Either one of us.

Mr. BILIRAKIS. Thank you. Thank you, Mr. Chairman.

Mr. EVANS. Doctor, thank you for your patience with us today in about the ninety minutes you testified. We warmed you up for the Appropriations Subcommittee. We dismiss you now at this time.

Dr. DITZLER. Thank you.

Mr. EVANS. Before I call the first panel of veterans' organizations together I would like to note for the record that Congressman Dan Mica was at the Committee hearing earlier and without objection he has requested that his statement be made a part of the record of this hearing.

[The prepared statement of Hon. Dan Mica appears on p. 58.]

Mr. EVANS. We would like to call the first panel of veterans' organization representatives before us—the American Legion, Paul Egan and John Sommer, and representing the Veterans of Foreign Wars, Dennis Cullinan, and representing the Disabled American Veterans, David Gorman, if they would come forward and be seated?

We would advise them also that their complete statements will be made part of the record. If they would like to summarize from those statements, that would be appropriate, and we would start with Mr. Egan. Thank you.

Mr. EGAN. John Sommer, the Deputy Director of our National Rehabilitation Commission, will testify for us, but since the subject of the Providence Nursing Home project came up, I think it is important that the record be straight.

Our people in Rhode Island find the competitive processes are not reflective of need in Rhode Island, and in fact, it is my understanding that the health care planning people at Rhode Island also contradict those numbers, and with that in mind, we would request that Senator Garn, the Chairman of the Appropriations Subcommittee in the Senate, to ask for another GAO look, and without having seen the results of that, it is important to note that at least as far as we are concerned at the time-being at least as far as the Senate Appropriations Subcommittee is concerned, that issue is still very much on the table.

Mr. EVANS. Mr. Sommer?

STATEMENT OF JOHN F. SOMMER, JR., DEPUTY DIRECTOR, NATIONAL VETERANS' AFFAIRS AND REHABILITATION COMMISSION, ACCOMPANIED BY PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Mr. SOMMER. Mr. Chairman, thank you. We would like to begin by thanking you, Chairman Montgomery, Mr. Hammerschmidt, and the members of the full committee for recommending to the Budget Committee that $23 million be added to the fiscal year 1987 construction budget for the construction of the nursing homes in Tampa, FL, and Hampton, VA, and the design funds for the clinical addition at Aspinwall and the site acquisition fund for the hospital at Palm Beach.

This is a significant improvement over the Administration's proposal and these projects are certainly badly needed.

As we have stated over the past several years, it is unwise today particularly to reduce the funding for medical construction when the capital plant of the VA health care system is deteriorating.

It seems to us that OMB has it in mind to allow the system to continue to deteriorate through underfunding of the renovation and the replacement program which is one of the primary reasons for the current state of degeneration. So we have to ask what happens now? Is it OMB's intention to reduce the system until there is none? It would appear to us that the budget document is actually a policy statement of the administration. It is obvious that the Veterans' Affairs Committee shares our commitment and the Committee's recommendation to include funding for the four projects that were previously mentioned is sincerely appreciated by the American Legion.

We are also extremely concerned with OMB's, "plan for the future" in nursing care, that dictates no new independent nursing home construction by VA and bigger reliance on community nursing homes. As we have explained in detail in our full statement, this is dangerous for at least two reasons that we see.

First, some private sector nursing homes do not want veterans who are in need of specialized care. This is because community nursing homes are profit oriented operations and these cases are certainly not profitable.

In addition to that, there is an unequal distribution of long-term care resources across the country that results in shortages of available nursing beds in some areas. In some cases, they are unequally distributed in a given State.

These are but two examples of why we are thoroughly convinced that it is a bad idea for the Veterans' Administration to cease construction of nursing home care units.

Mr. Chairman, we would again like to take this opportunity to thank you and the members of the subcommittee and the Full Committee for your continued commitment and foresight that were exhibited by the recommendations to the Committee on the Budget in the report of February 27.

That completes our summary.

[The prepared statement of the American Legion appears on p. 59.]

Mr. EVANS. Thank you very much. Mr. Cullinan, we would like it if you would like to make a statement.

STATEMENT OF DENNIS M. CULLINAN, SPECIAL ASSISTANT, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

Mr. CULLINAN. Thank you. Mr. Chairman and members of the subcommittee, I would like to thank you for this opportunity to present the views of the Veterans of Foreign Wars with respect to the construction authorization for the VA's Department of Medicine and Surgery.

I would also wish to express at this time our appreciation for the Veterans' Affairs Committee proposal to increase funding for construction.

The VFW is very alarmed at the administration's proposed construction budget for the VA's Department of Medicine and Surgery for fiscal year 1987 of only $408 million in new budget authority. This is a reduction of over $208 million from fiscal year 1986 and clearly demonstrates that in order to save a few dollars the administration is willing to foresake this Nation's moral commitment to provide high quality health care to its veterans now that the need is on the rise.

Considering that the health care needs of the aging veteran population will continue to increase and place an even greater demand on the VA's delivery system, the administration's proposed reductions of the VA's medical care construction authorization would serve to exacerbate a situation which is already critical and demonstrates what is to our mind lack of sound judgment or commitment or both.

The proposed authorization for fiscal year 1987 for replacement and modernization activity is only about $212 million. It is a reduction of almost $189 million from fiscal year 1986, and would mean that the VA could not maintain even its current physical structures. Fifty-three percent of all VA beds are housed in buildings which are 30 years or more old. It can be readily seen that unless the construction program is quickly and substantially enhanced, the shortage of space will rapidly worsen. Reducing this program as is being proposed by the administration could spell disaster.

In this regard, it is inconceivable to us that the administration would propose reducing the authorization for VA nursing home construction from $22.5 million in fiscal year 1986 to only $4 million in fiscal year 1987. This paltry funding level will result in an all-new VA nursing home projects being cancelled and conversion couldn't possibly make up for this lack.

Similarly, it may only be viewed as appalling that no new funding is to be provided for fiscal year 1987 for VA domiciliaries.

The VFW applauds the proposed increase of over $21 million in budget authority for grants for construction of State extended care facilities which would set the authority for this program for fiscal year 1987 at over $42 million.

Even so, we would point out that such a large increase in funding may result in the inefficient utilization of precious funds. Further, it is also apparent that the administration and OMB through pursuing such a course are attempting to escalate the privitization

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of veterans' health care. This to our mind will eventually result in fewer and fewer veterans being provided with less and less health care.

With this in mind, we point with alarm and concern at the proposed diminishment of the VA's major construction activities funding along with the proposed reduction of over $24 million in its minor project authorization. In sum, such a lower level of funding would constitute a severe blow to the VA's health care system and a slap in the face to this Nation's veterans.

Thank you, Mr. Chairman. That concludes my statement.

[The prepared statement of Mr. Cullinan appears on p. 67.]

Mr. EVANS. Thank you very much. Mr. Gorman?

STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

Mr. GORMAN. Thank you very much, Mr. Chairman. It is a pleasure to be here again appearing before the subcommittee this morning.

I would like to begin my summarization by stating categorically that we in the DAV believe that the $465 million total program for VA medical construction is woefully inadequate to meet the needs of the system itself. We have heard testimony this morning about the administration's new policy towards no new nursing home construction. We agree that that policy as apparently dictated by OMB and by the VA is extremely shortsighted in view of the needs that are documented and the demands that will be placed upon the system by an aging veteran population in the next few years.

We would also comment that while the administration intends to place a greater share of VA nursing home patients in the private sector, to our knowledge, there has been no documented study or assessment done of the private sector's actual ability to accommodate for an increased demand of older veterans. There are a number of States now that we are aware of that have moratoriums on nursing home construction. This over-reliance on the private sector is of great concern to us.

Also we heard this morning Dr. Ditzler testify as to the VA's plan to convert a number of acute hospital care beds to long-term nursing home care beds. While the DAV agrees to the concept of converting some acute care beds that aren't being used now into nursing home care beds, our concern is simply that based on the continued shutdown or closing of acute care beds, that simply not enough conversion is actually taking place in the system—not as much as could be anyway.

The DAV does support the VA's request for advanced planning funds and the request for the design fund of $19 million. Also, we are again pleased to see the continued growth in the grants to States for nursing home and domiciliary construction which has increased by approximately $21 million this year.

Mr. Chairman, the DAV is aware that the VA has for some time been trying or attempting to develop a prototype nursing home for construction of nursing homes across the country, basically adapta-

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ble in all possible places. We certainly support the concept of this prototype.

However, we are aware of a recent Inspector General's audit that discovered serious flaws in the VA's attempts so far to develop that prototype. The IG concluded that the VA Department of Medicine and Surgery had not accomplished its major program initiative of developing a nursing home care unit prototype that provided quality, timely, cost-effective facilities to meet the long-term care needs of veterans.

Because these prototypes will in our opinion produce a substantial savings both in dollars and time, we would urge the VA to come together and try to resolve this situation.

Also, Mr. Chairman, we heard some talk and testimony from Dr. Ditzler this morning about the reorganization of the Office of Construction into the Department of Medicine and Surgery. Again we would support the basic concept of this theory and I know the VA has spent a lot of time and nearly $1 million in contracting out this study.

We would urge the VA during implementation of this reorganization to streamline the operation and to affix accountability and responsibility where it should be.

Mr. Chairman, in concluding I would, as did my colleagues, like to thank you and members of the full committee for the actions that you have taken that restored the $23 million to the construction fund. I think it again shows the commitment of this committee toward the Veterans' Administration.

Thank you.

[The prepared statement of Mr. Gorman appears on p. 72.]

Mr. EVANS. Thank you. Well, you have apparently come to the conclusion that the OMB is systematically reducing the size of the VA medical care system, as Mr. Sommer said, if not the intention to reduce the VA system until there is none.

I think most of us on the subcommittee agree with that assessment. We are today talking about the construction budget, but we all have previously testified that reductions in the fiscal year budget are also going to lead to an inadequate budget for those problems.

My question is this—what is the grass roots sentiment of your members of your respective organizations as taxpayers facing the deficit and also as veterans with eligibility for VA benefits?

What is their reaction to OMB's apparent plan to drastically cut back resources for the VA?

Mr. SOMMER. Well, Mr. Chairman, I think the members of the American Legion are very much aware that the Veterans' Administration over the past several years has been a model of fiscal prudence in comparison to a lot of the other Federal programs, and they are very much aware of the fact that the total percentage of the Federal budget that is consumed by veterans' programs has been shrinking over the past 10 years from a full 5 percent to somewhere in the neighborhood of 2.5 percent in the current fiscal year. We attempt to keep our members well informed of the budgetary process of the VA and of the fact that the VA does not have a budget that is ballooning or adding a great deal to the Federal

deficit, and so the feedback that we get from our members is that there is support of the positions of our organization.

Mr. CULLINAN. Mr. Chairman, as you may know, the VFW recently concluded its Washington conference, and at the conference there was a good representation from the grassroots.

There seems to be a consensus that something has to be done about the deficit. Our people are worried about it.

The consensus would also hold that the VA has been asked to do too much. In concurring with Mr. Sommer here, the VA seems to be a model of economy, and our people are worried about that.

Mr. EVANS. All right. Mr. Gorman?

Mr. GORMAN. I think our members share the views as expressed. Also, I think it is important to note that the VA has suffered significant budgetary reductions and been subjected to action that produced savings over the last 5 years of more than $1 billion. Also the VA is not growing in any actual dollar expenditures when inflation is taken into account. I think our members realize that.

I think they are also appreciative of what the VA has done and continues to do to meet their health care needs as well as their benefit needs.

I think also our members and our organization at the national level have consistently held fast to the point that well, we have sacrificed in the past by seeing the VA's budget as it has been over the years, and I think that if it is an equitable treatment for all Federal programs, domestic and defense, we would be more than happy to contribute our fair share of the burden in continuing that.

Mr. EVANS. Thank you. The gentleman from Florida?

Mr. BILIRAKIS. Thank you, Mr. Chairman. I would submit with all due respect to all of you four gentlemen, that consistent with the chairman's question to you, that the grassroots really doesn't know. You all do a great job and I compliment you every time.

I have just finished a series of five veterans' workshops in the district which included VA personnel on the panel to relay to the veterans and their families the benefits that are available to them and what not. Four and five were pretty darned well attended. We found that the grassroots doesn't concern itself adequately. As hard as you may work, and you do, and the great periodicals that you get out and I receive three of them, they just don't seem to show the interest that they should show. I don't know but do you have any suggestions as to how you can teach them more? If you did, I think that your effort would be made an awful lot easier. My effort would also be an awful lot easier.

There has been a 55-percent increase in veterans spending over the last 10-plus years as against 160-plus percent increase in other Federal spending. I am not saying that veterans spending maybe should have been 160-some percent increase to keep up with the rest of it, but if the rest of it were closer to the 55, 60, or 65 percent, we wouldn't be concerned today with the horrors of Gramm-Rudman and these budgetary problems. So yes, the Veterans' Administration and the veterans have taken more than their share of the burden over these last 10-plus years and I think you all and the Veterans' Administration are to be commended for the great job in general that has been done.

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In spite of all that, I would ask possibly the entire panel, maybe the people that follow Bob and David if they would submit for the record in the interest of time answers to the following questions: What do you all believe would be or should be the most ideal mix of funding for nursing home facilities between the Veterans' Administration, the State and the private sector? And we have got to face up to reality. We have got to always consider that we have got to be bringing the private sector into these pictures even though it may bother us. That is just the real world. An additional question would be what facilities in your view are most in need of construction funds aside from those funded by the committee's recommendations for fiscal year 1987? And I am not really sure what those might be, but I guess basically what I am saying is I hope that our committee has impressed upon you the fact that we are doing the best we possibly can on your side, but help us out maybe with some of this additional information.

One interesting point was raised by Mr. Egan. You had said you had reason to believe that the heirs and descendants of the original grants of the land to the United States might try to come and reclaim the land if transfer were attempted.

Can you be more specific about why you believe it could happen?

Mr. EGAN. I defer to John Sommer on that one.

Mr. BILIRAKIS. Okay.

Mr. SOMMER. Yes, sir, Mr. Bilirakis—we have been in an ongoing discussion with the American Legion of California for at least the last 5 years on this very issue, not because it had been proposed by the Government to excess the land but because there has been a great push by developers in California to try to take some of this land, and they have done a great deal of research. They have produced copies of the original deeds to the land. They have done a lot of legal research, and it is felt very strongly that because the original deed of the property, which I believe was set forth in 1888, specifically states that the land was to be used only for the care of disabled veterans, the heirs who continue to live in California would take issue with any change to that intent that might be made.

Mr. BILIRAKIS. So your point is that even the attempt might result in the loss of the land to the Government and also the loss of the potential revenue that might come from the sale of the land?

Mr. SOMMER. That's correct.

Mr. EGAN. If the Congress approved excessing of that land, it is likely that an injunction would immediately be placed on any action.

Mr. BILIRAKIS. What is the VA's reaction to this, do you know?

Mr. EGAN. I have no idea. It might be more appropriate to ask Mr. Miller over at OMB.

Mr. BILIRAKIS. Well, all right.

Mr. EGAN. I would like to address in conceptual terms one of the questions that you asked us to answer for the record. It concerns provision of nursing home care in the private sector.

I think we can all agree that the availability of nursing home resources in the private sector is inadequate, which of course is why we keep saying that this budget proposal, to rely on the private sector makes no sense. Until there are some resources, some fund-

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ing resource, to come to pay for the cost of long-term nursing home care, it is not likely that the private sector is going to respond.

We have suggested—this is the second year in a row— that probably it would be a good idea to make some inquiry of some of the insurance companies that provide health insurance, ask them why they are not providing some kind of insurance against long-term care because if that was marketable, insurance of that kind was marketable, you can bet that the private sector would be tripping over itself to get it.

Mr. BILIRAKIS. The Energy and Commerce Committee that I also serve on, the Health and Environment Subcommittee in particular, is trying to address that problem.

Thank you, Mr. Egan. Thank you, Mr. Chairman.

Mr. EVANS. Thank you. I excuse this panel at this time. Thank you for your testimony today.

Mr. SOMMER. Thank you, Mr. Chairman.

Mr. EVANS. At this time we will call the second and last panel before us today—Bob Moran and Kim Beasley with the Parlyzed Veterans of America, and David Passamaneck of the AMVETS, if you would all come forward?

STATEMENT OF BOB MORAN, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA, ACCOMPANIED BY KIM BEASLEY, ASSOCIATE NATIONAL SERVICE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. MORAN. I will summarize from my written testimony.

Again, I would like to introduce myself. I am Bob Moran, Associate Legislative Director with PVA. I am accompanied by Mr. Kim Beasley, Associate National Service Director with PVA. It is a pleasure to be here today with you.

I would like to take an opportunity to elaborate on several critical issues regarding VA construction programs and their relationship to the recently completed Booz, Allen, Hamilton RTKL comprehensive study of the VA construction process.

In a letter to PVA Executive Director Jack Powell dated November first, 1985, the VA Administrator informed PVA that he had made the decision to implement the procedural recommendations of the Booz, Allen, Hamilton study as the best means to make major improvements in the timely and efficient delivery of health care construction.

In addition, he announced his intention to transfer the Office of Construction into DM&S in order to reduce functional duplication, to eliminate conflicting roles, and to fix accountability in that organization.

In short, the purpose of the Booz, Allen study was to streamline and correct organizational/procedural inefficiencies which would imply a reduction in FTEEs. This coupled with the decrease in construction activity leaves one puzzled as to the proposed increase in FTEEs. In light of the current budgetary climate and pressures to adopt efficient operational practices, the study appears to be timely.

However, it is unclear what the VA is doing to implement the study which reportedly cost $1 million. The final report recom-

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mended a number of procedural and organizational improvements which if implemented would significantly strengthen the construction program. This study indicates a need for a long-range strategy for meeting system-wide construction needs, an efficient resource allocation methodology to meet construction needs, streamlined procedures to carry out construction projects, and a reduction in time required to plan and implement construction.

Furthermore, the study reveals that while sufficient numbers of staff do exist to carry out the health care facility construction process, more efficient use of staff resources can be realized.

A common thread running through all of the study's analyses points to deficiencies in medical facility planning. The VA's annual 5-year medical facility construction needs assessment document submitted to Congress annually is not an assessment of needs at all. It is simply an executive summary of the major construction projects requested each year by every medical center. There is no assurance that scarce resources are being distributed where the need is most acute.

The Booz, Allen, Hamilton study proposes procedural changes that would remedy this and ensure that construction dollars can be allocated equitably and efficiently. The recommendations of the study are also consistent with a statement made by Senator Alan Cranston last spring in a letter to Harry Walters, I quote, "I believe it is imperative that the VA develop an approach that seeks to allocate scarce funding over a greater number of projects in order to more adequately serve veterans across the Nation."

We look forward to working with this subcommittee and the VA to ensure timely implementation of the Booz, Allen recommendations which will result in a system that efficiently and effectively meets medical construction needs within budgetary restraints.

This concludes my statement.

Mr. EVANS. Thank you. Mr. Passamaneck?

[The prepared statement of Mr. Moran apprears on p. 89.]

STATEMENT OF DAVID J. PASSAMANECK, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Mr. PASSAMANECK. Thank you, Mr. Chairman. I have a terrible cold. I may sound pretty bad and cough once in a while, if you will bear with me.

I will summarize the contents of my printed statement which I request be included in its entirety in the record.

Mr. Chairman, AMVETS is pleased to address the President's proposed fiscal year 1987 budget for the Veterans' Administration's medical construction authorization request.

Although the President has declared his awareness of the special status of veterans in our society, his Administration has repeatedly failed to recognize the programs established for the rehabilitation and benefit of those who have borne the battle are an integral and morally compelling part of the cost of national defense as much as the cost of current military hardware.

Although the defense and veterans budgetary categories are technically separate, the Veterans' Administration budget cannot be lumped together with other domestic programs not related to

the powers and responsibilities of national defense. The President has rightfully and courageously advocated the continued recovery of our defense capability. However, when it comes to paying the solemn debt we owe as a nation to those who came back from that war, the Vietnam War and the World Wars and Korea as well, the special earned place of veterans is forgotten.

So long as the President's defense policies do not include priority fulfillment of our obligations to our veterans, those policies are sadly inconsistent and considerably self-defeating. AMVETS as we have repeatedly maintained in resolutions adopted by our national conventions and testimony before Congressional committees strongly supports those policies which seek to control Government spending, control inflation and interest rates, and perpetuate the economic prosperity which we are now enjoying without raising taxes.

However, we specifically reject the cynical concept that all Government programs except the politically untouchable equally deserve to be cut in order to comply with a pre-determined deficit level. Any program to control budget deficits which ignores the essential priority of expenditures for national defense, including veterans' entitlements, is completely unworkable and constitutes a dangerous threat to our very existence as a nation.

Under this budget, overall construction will be cut some $332 million over and above the 1986 Gramm-Rudman cut of $21.8 million, resulting in a cancellation of seven previously planned nursing homes.

Mr. Chairman, as we look at medical construction, we all agree that many VA facilities are aged and in need of replacement or modernization. Focus needs to be centered on all construction plans, present and future. How can or will the VA respond to a veteran population which places greater annual demands on the VA for medical care? What conclusions can be drawn when a construction account is proposed at $408 million, down $368 million since fiscal year 1985? What will become of the major and minor construction projects? How is the VA planning for the aging veterans and their related medical problems?

A fresh coat of paint hides little and does little. The replacement and modernization account is down $188.8 million, with nursing home care down an astounding $18.4 million to $4 million. Even the domiciliaries are down $22.9 million with no appropriation requested for fiscal year 1987.

One possible bright spot in the medical account may be the grants for construction of State extended care facilities proposed at $42.4 million, up $21.5 million over fiscal year 1986. $20 million may build a lot of State veteran nursing homes which will relieve VA of finding space for veterans in its system. We are, therefore, not surprised that there is a dramatic upturn in funds in this account.

The DM&S budget seeks a massive shift of nursing home care to State and community, read private, nursing homes, even though such facilities are not available in many areas of the country. The adoption of this budget will set the entire VA medical delivery system on a rapid course to extinction, thus destroying what over 55 years of heartbreaking struggle has built into a living monu-

ment to the pride and gratitude of a free people for the sacrifices of those who shouldered arms in defense of our Nation.

We cannot live with this budget or the selfish, narrowminded, penny-pinching philosophy on which it is based.

This concludes my statement. I will be pleased to answer any questions you might have.

[The prepared statement of Mr. Passamaneck appears on p. 94.]

Mr. EVANS. Thank you both. I would ask the same question. What is the grass roots view of your members as taxpayers concerned about the deficit and also as veterans concerned about these proposed cuts that we have talked about in construction and Medicare, medical care account of the VA?

Mr. MORAN. Well, very briefly, we would have to agree with the Legion as far as grass roots effort, members. Mr. Gorman with the DAV stated in the last 5 years about $2 billion in savings as far as veterans' programs—it would be nice if we could bring all of our members to Washington for about 3 or 4 months during the budget process and just let them see exactly what takes place.

They are concerned. I think all Americans as well as veterans are concerned about reducing the Federal deficit.

To reiterate what most of my colleagues here said, we feel that we have taken our fair share. We have taken possibly more than our fair share. Several years ago when COLAs were going to be held up, most of the veterans organizations supported that and said we would take a delay in our COLA. I think last year, even this year when everyone was possibly going to not receive COLA we said we would take our fair share if all Americans were created equal, so we are concerned. We try to inform our members as best we can. Again, I think if they were here and could see the process, they would see that sometimes what we are up against, and it is not an easy task.

Mr. PASSAMANECK. Let me just say this regarding the whole situation—with respect to priorities and the deficit and the place of veterans' programs in that picture, first of all, AMVETS realizes as much as anyone else that has been involved in this business that raising higher taxes and high interest rates or ever-rising interest rates, whatever you want to, however you want to put it, hurt veterans perhaps more than they do most anybody else.

We don't want those things. We want the current prosperity that we are in right now to continue. We also, however, feel that veterans are uniquely special, that they must come first when it comes to the holding on appropriations, and that they must come last when we are talking about cutting.

We don't actually and completely agree with the philosophy that my colleague over here reiterated a few minutes ago that, you know, we really went along with it in years past. We don't really think we are going to go along with it anymore, this idea let's take an equal share of the cuts. Well, it turns out every time you say take an equal share of the cuts, we get it in the neck. We don't get an equal share. We have a proportionately much worse share of the cuts because the fact of the matter is that because of the responsibility of this committee, the veterans' organizations, and the VA in formulating these policies and implementing them over the

years, the Veterans' Administration budget is a sterling example of fiscal conservatism.

If the rest of the Government followed the example of the VA we wouldn't have a deficit, certainly not as big as we have, and we feel that enough is enough. We start talking about equal share. What about the people whose budgets have been going up 50, 60 percent over the last 2 or 3 years? They should have a bigger cut you see rather than the VA which really our true spending has in fact been declining over the last 15, 20 years.

Mr. EVANS. Thank you. The gentleman from Florida?

Mr. BILIRAKIS. Thank you, Mr. Chairman. I, too, would like to commend both these gentlemen along with the others who preceded them for the great work that they do on behalf of the veterans.

Mr. Passamaneck, I very much appreciate your comments regarding the continuing recovery of our defense capability. I am always disappointed when we don't get more emphasis put on that by our fellow veterans because they accomplished all the sacrifices and what not in the past, and at the same time, sir, I congratulate you for your comments on, well, basically when you said that, and if the legitimate needs of those who serve us are forgotten, the most sophisticated machinery will avail us little, and that is certainly quite true because the most sophisticated machinery which I have been supportive of is nothing without the person there to push the right button and to make a proper decision.

Saying that, I would merely ask you both to furnish us the same responses that I have asked the other two groups, and thank you again for coming.

Thank you, Mr. Chairman.

Mr. EVANS. Thank you. This panel is dismissed, and the hearing is concluded.

[Whereupon, at 10:26 a.m., the subcommittee was adjourned.]

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APPENDIX

REMARKS OF HON. JOHN PAUL HAMMERSCHMIDT
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND
HEALTH CARE ON VETERANS ADMINISTRATION
MEDICAL CONSTRUCTION AUTHORIZATION REQUEST
FOR FY 1987
MARCH 6, 1986

THANK YOU, MR. CHAIRMAN.

THIS IS THE THIRD HEARING WE HAVE HELD ON THE PROPOSED BUDGET SUBMITTED BY THE VETERANS ADMINISTRATION. WE HAVE HEARD TESTIMONY ON THE PROPOSED OVERALL BUDGET AND THE PROPOSED MEDICAL BUDGET, EXCEPT FOR CONSTRUCTION, WHICH IS BUDGETED SEPARATELY. TODAY WE TAKE UP THE PROPOSED CONSTRUCTION BUDGET.

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THE COMMITTEE HAS ALREADY MADE WELL KNOWN ITS VIEWS ABOUT THE NEEDED ADDITIONS TO THE CONSTRUCTION BUDGET. THE BUDGET COMMITTEE RECEIVED OUR BIPARTISAN RECOMMENDATIONS ON FEBRUARY 27. THAT MAY SEEM LIKE PUTTING THE CART BEFORE THE HORSE, BUT THE BUDGETARY PROCESS IMPOSES DEADLINES WE MUST MEET. THIS HEARING WILL NONETHELESS ALLOW THE RECORD TO BE FILLED OUT MORE COMPLETELY WITH THE TESTIMONY OF THE VA IN SUPPORT OF ITS PROPOSED BUDGET AND WITH THE VA'S RESPONSES TO OUR QUESTIONS. THEN THE BUDGET COMMITTEE WILL HAVE THE DIFFERENT POINTS OF VIEW TO CONSIDER.

WE CANNOT AFFORD TO BE SHORTSIGHTED WITH THE VA'S CONSTRUCTION BUDGET. AS DR. DITZLER STATES IN HIS TESIMONY, OVER 53 PERCENT OF VA HOSPITAL BEDS ARE IN BUILDINGS OVER 30 YEARS OLD. THE HOSPITAL SYSTEM BUILDINGS CANNOT BE ALLOWED TO BECOME UNSAFE, UNSANITARY AND UNSUITABLE FOR DELIVERY OF QUALITY STATE-OF-THE-ART MEDICAL CARE TO VETERANS.

CONSEQUENTLY, THE VA MUST BE GIVEN THE RESOURCES TO MAINTAIN, IMPROVE, RENOVATE, AND WHEN NECESSARY, TO REPLACE EXISTING HEALTH CARE FACILITIES OR BUILD NEW ONES. THE ALTERNATIVE IS TO HAVE A HEALTH CARE SYSTEM WHICH SLOWLY AND SURELY CRUMBLES AWAY UNTIL IT IS NO LONGER VIABLE.

PLANNING AND ACTUAL CONSTRUCTION WILL HAVE TO TAKE INTO ACCOUNT THE SHIFT IN THE VETERAN POPULATION TO THE SUNBELT. THE GREATER AVERAGE AGE OF VETERANS ALSO IS HIGHLY SIGNIFICANT, BUT THE VA'S HOSPITALS SHOULD NOT BE CONVERTED WHOLESALE INTO A CHAIN OF NURSING HOMES AS WE MEET THE NEEDS OF OLDER VETERANS.

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IT SHOULD BE RECOGNIZED THAT THE VA HEALTH CARE SYSTEM IS AN IMPORTANT NATIONAL RESOURCE TO BE MANAGED IN A WAY CONSISTENT WITH THE NEEDS OF VETERANS, MEDICAL RESEARCH AND EDUCATION, AND NATIONAL SECURITY. EACH OF THESE IS PART OF THE VA MISSION, AND IS ESTABLISHED BY LAW.

MR. CHAIRMAN, I AM LOOKING FORWARD TO HEARING TODAY'S WITNESSES; MOST OF THEM ARE FAMILIAR TO US AND WE RESPECT THEIR VIEWS, WHETHER THEY ARE WITH THE VA OR WITH VETERANS' ORGANIZATIONS.

THANK YOU, MR. CHAIRMAN.

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Testimony of Representative Tony P. Hall
on fiscal 1987 Veterans Administration Medical Construction
before the Subcommittee on Hospitals and Health Care
House Committee on Veterans' Affairs
March 6, 1986

Mr. Chairman and members of the subcommittee, thank you for giving me the opportunity to testify on the Veteran's Administration medical construction authorization requests for fiscal 1987.

I am testifying in support of the administration's request for $8.4 million for the design of a new hospital building at the Dayton, Ohio Veteran's Administration Medical Center within the 3rd Congressional District which I represent.

When completed, the building will accommodate medical, surgical, and psychiatric beds, as well as selected diagnostic treatment and support functions. The modern, 11-level building will house a total of 618 beds, including 116 medical, 138 surgical, 105 psychiatric, 24 neurology, 35 rehabilitation, and 200 intermediate.

The building, which is scheduled for construction in fiscal 1988, is expected to cost a total of $84 million. It will replace Brown Hospital, the existing acute care hospital building. It is the result of a planning process which began in 1979 when it was determined that Brown Hospital was inadequate to meet the medical needs of the veterans.

The project contained in the fiscal 1987 budget request is an alternative to an earlier proposal to renovate Brown Hospital and construct a new

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building. This plan was estimated to cost a total of $150 million. I am satisfied that the alternative contained in this budget request is a cost-effective compromise that will provide Ohio veterans with a basic level of essential health care services. The project now under consideration recognizes both budgetary constraints as well as an urgent need to provide modern medical facilities.

On several occasions, I have visited Brown Hospital, and I can assure the members of this subcommittee that the facilities do not meet my expectation for the high quality, modern service to which I believe our veterans are entitled.

Most noticeable to me is the lack of privacy for many of the beds. The intensive care units are not designed to current standards which permit medical personnel to closely watch the patients. Corridors are narrow, and there are too few exits. The building is not seismic resistant.

The Joint Commission on Accreditation of Hospitals and other accrediting survey teams have determined that Brown Hospital has serious space, functional, structural, fire, and safety deficiencies.

These deficiencies are too large and too numerous to be corrected with renovations, thus requiring the new building.

The Dayton VAMC is the third oldest veterans' facility in the nation. It serves a primary service area of 28 counties in Ohio and one county in Indiana with a total of 387,000 veterans. It is a major teaching hospital for the Wright State University School of Medicine, providing training for over 100 residents and 200 medical students.

I urge the members of the subcommittee to approve the budget request for the Dayton VAMC.

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Construction, Major Projects
VAMC Dayton, Ohio
Bed Replacement and Modernization

I. Budget Authority

Total Estimated Cost	Available Thru 1986	1987 Request	1988 Or Future
$84,000,000	...	$ 8,400,000*	$75,600,000

*Funds being requested in 1987 are for design only.

II. Description of Project

This project proposes to construct a ten-level addition to accommodate medical, surgical, psychiatric, intermediate, neurology, and rehabilitation beds as well as selected diagnostic, treatment, and support functions. The addition will be sited to the east of the existing hospital building and the 1980 clinical addition, Building 310. The new addition will house 115 medical (includes 10 dialysis beds), 136 surgical, 106 psychiatric, 200 intermediate, 24 neurology, and 35 rehabilitation medicine beds, for a total of 618 beds. The existing hospital building, Building 300, will be demolished upon completion of this project.

The 1995 parking analysis shows a need for 760 parking spaces. Upon completion of this project, the Medical Center will have a surplus of 437 spaces. It is planned through this project to replace the 223 parking spaces which will be lost to new construction and relocate a number of spaces which are required to be near or adjacent to the acute care medical complex. This project also includes road alignment, landscaping, and site utilities.

Compliance with the National Historic Preservation Act of 1966, Section 106, will be necessary. An environmental assessment was accomplished with a finding of no significant impact and was published in the Federal Register on June 11, 1984.

III. Justification for Project

The existing main hospital building was constructed in 1931 and has never been significantly renovated. This building has serious space, functional alignment, structural, fire and safety, seismic, and patient privacy deficiencies cited by the Joint Commission on Accreditation of Hospitals (JCAH) for medical, surgical, intermediate, psychiatric, and intensive care nursing units at this Medical Center. This project will consolidate into one building presently fragmented functions and provide appropriate space for diagnostic/treatment and other support facilities in accordance with current standards.

Intermediate medical beds will be relocated from the circa 1940 building (Building 302) to the acute care complex. This building is functionally and spatially inadequate for patient occupancy and the existing structural system limits efficiency of space and functional design.

This project is intended to resolve space, functional, and physical deficiencies. Additional resources will be required to meet increased demand for inpatient and outpatient care, and to maintain and care for more sophisticated medical equipment and treatment modalities. Cost avoidance may occur due to more energy efficient construction, construction improvements, but is difficult to document and not obtainable.

IV. Background

There were three alternatives developed for this project. All alternatives include the continued use of the clinical addition (Building 310), education building (Building 307), and the basic sciences building (Building 315) for the following functions: ambulatory care, laboratory, surgery, library, educational, and research facilities.

Alternative 1: This alternative would construct a seven-level addition to the east of the existing hospital building and the clinical addition to accommodate medical and surgical beds and selected diagnostic, treatment, and support functions. It would provide major renovation and adaptative reuse of the main hospital building (Building 300) for psychiatric, intermediate, surgical, and rehabilitation medicine beds, as well as selected patient treatment and administrative functions.

Alternative 2 (modified): This alternative would construct a ten-level addition to the east of Building 310 to accommodate all acute, intermediate, and psychiatric beds and the major clinical and support functions. Building 300, the main hospital building, would be demolished.

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Construction, Major Projects
VAMC Dayton, Ohio
Bed Replacement and Modernization

Alternative 3: This alternative would construct a new five-level patient care tower east of Building 310 for most of the medical and all of the surgical beds, as well as selected diagnostic and treatment departments. The existing main hospital building would be renovated for psychiatric, rehabilitation medicine, and intermediate beds, as well as other clinical and support functions, minimally renovating recently remodelled areas. This alternative would include a two-level addition on the clinical addition to accommodate intensive care units, clinical cardiology laboratory, respiratory care, and supply processing and distribution.

All alternatives were developed using the following current and 1995 projected workloads.

	Current	Projected
Beds	679 (includes 7 dialysis beds)	618 (includes 10 dialysis beds)
Outpatient visits	63,584	72,140*

*The latest planning allocations indicate this number; however this allocation is now being reviewed based on current information and may be adjusted upward.

Alternative 1 was rejected because, although it would have corrected deficiencies at the Medical Center and provided new space for most of the acute beds and associated clinical and support functions, recent studies have identified major structural deficiencies in the Brown Hospital buildings. The cost of renovation, including seismic corrections, is now substantially greater than the comparable cost of new construction.

Alternative 2 (modified) was selected because it would be the most functional and economical approach to correcting cited deficiencies at the Medical Center.

Alternative 3 was rejected because several diagnostic and treatment areas would have been below space planning criteria and provide poor functional relationships to bed services. Opportunities for future expansion would have been difficult, distribution of meals and supplies would have been made difficult through a maze of corridors, and supply processing and distribution would have been poorly located relative to the dock.

V. Correction of Code Deficiencies

New construction will be accomplished in accordance with all National Fire Protection Association, JCAH, and handicapped accessibility codes and requirements.

VI. Schedule

Complete preliminary plans	08/20/86
Complete construction	03/07/91

VII. Project Cost Summary

		Cost
New Construction 511,504 gross square feet @ $115.00		$58,823,000
Alterations		N/A
Subtotal (new construction and alterations)		$58,823,000
Other Costs:		
a. Sitework, utilities, demolition and surface parking	$4,000,000	
Total Other Costs	4,000,000	4,000,000
Total Estimated Base Construction Cost		$62,823,000
Construction Contingency (10 percent)	6,282,000	
SHA(da) Allowance	N/A	
Contingency Reserve	6,282,000	6,282,000
Technical Services (10 percent)		6,910,000
Impact Costs		500,000
Total Estimated Base Cost		$76,515,000
Inflation Allowance		7,485,000
Total Estimated Project Cost		$84,000,000

Construction, Major Projects
VAMC Dayton, Ohio
Bed Replacement and Modernization

VIII. Annual Operating, Staff and Equipment Cost

	Project Activation Costs		Present Facility Operating Costs	
Equipment cost		$30,850,000		N/A
One time non-recurring cost		1,266,000		N/A
Recurring costs:				
Additional manpower	FTE: 247	$ 7,163,000	FTE: 1685	$45,065,951
Other recurring		4,005,783		13,687,111
Total recurring		$11,168,783		$58,753,062

IX. Executive Order 12372 Compliance

The VA notified State and Areawide Clearinghouses on January 15, 1981. No response was received from either clearinghouse.

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STATEMENT

BY

JOHN W. DITZLER, M.D.

CHIEF MEDICAL DIRECTOR

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ON

MARCH 6, 1986

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, I AM PLEASED TO APPEAR BEFORE YOU THIS MORNING TO PRESENT TESTIMONY CONCERNING THE VA'S CONSTRUCTION REQUEST CONTAINED IN THE PRESIDENT'S BUDGET FOR FY 1987. THE VA HEALTH CARE SYSTEM IS MADE UP OF 172 MEDICAL CENTERS, 116 NURSING HOME CARE UNITS, 16 DOMICILIARIES AND 53 INDEPENDENT AND SATELLITE OUTPATIENT CLINICS AND THIS SYSTEM STANDS OUT AS A LEADER IN THE PROVISION OF QUALITY MEDICAL CARE. THIS SYSTEM OPERATES IN OVER 5,000 SEPARATE BUILDINGS, WITH OVER 100 MILLION SQUARE FEET OF SPACE.

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2.

AS YOU KNOW, WE HAVE A TREMENDOUS CAPITAL INVESTMENT REPRESENTED BY THESE BUILDINGS, WHICH ARE AGING. OVER 53 PERCENT OF OUR HOSPITAL BEDS ARE IN BUILDINGS WHICH ARE OVER 30 YEARS OLD. THE VA MUST MAINTAIN A PHYSICAL PLANT CAPABLE OF DELIVERING STATE OF THE ART MEDICAL CARE; ONE WHICH CAN KEEP PACE WITH MODERN MEDICAL ADVANCES; AND RESPOND TO THE CHANGING NEEDS OF THE AGING VETERAN POPULATION. OUR CONSTRUCTION PROGRAM REPRESENTS A COMMITMENT TO A CAPITAL INVESTMENT PROGRAM WHICH IS DEDICATED TO MEETING THE FACILITY NEEDS OF A MODERN, COMPREHENSIVE HEALTH CARE DELIVERY SYSTEM TO PROVIDE FOR OUR NATION'S VETERANS.

THE FY 1987 BUDGET REQUESTS A PROGRAM LEVEL OF $465,170,000. THIS AMOUNT INCLUDES AN APPROPRIATION REQUEST FOR A MAJOR PROGRAM OF $358,208,000 WHICH INCLUDES $57 MILLION THAT IS AVAILABLE FROM PREVIOUS APPROPRIATIONS. WE ARE REQUESTING APPROVAL FOR FUNDING TEN MAJOR MEDICAL PROJECTS, $5 MILLION FOR THE ADVANCE PLANNING FUND TO DEVELOP FUTURE YEAR PROJECTS, $9.9 MILLION FOR ASBESTOS ABATEMENT, AND $19 MILLION FOR THE DESIGN FUND. WE ARE REQUESTING FUNDING FOR CONSTRUCTION OF MAJOR REPLACEMENT FACILITIES AT BOTH AUGUSTA (UPTOWN DIVISION), GEORGIA AND BALTIMORE, MARYLAND. THE PROJECT AT AUGUSTA WILL PROVIDE FOR 590 HOSPITAL AND 60 NURSING HOME CARE BEDS, WHILE THE BALTIMORE PROJECT WILL PROVIDE 324 HOSPITAL BEDS. WE ARE REQUESTING FUNDING FOR THE DESIGN OF A BED REPLACEMENT AND MODERNIZATION PROJECT AT DAYTON, OHIO, AND FOR AN ENVIRONMENTAL IMPROVEMENTS, PATIENT AND NURSING HOME CARE BUILDINGS PROJECT AT NORTH CHICAGO, ILLINOIS. IN ADDITION, THIS BUDGET REQUEST INCLUDES TWO CLINICAL IMPROVEMENT PROJECTS, ONE FIRE AND

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3.

SAFETY IMPROVEMENTS PROJECT, ONE ELECTRICAL IMPROVEMENTS PROJECT, ONE GENERAL PROJECT AND ONE RESEARCH AND EDUCATION PROJECT. OUR MINOR CONSTRUCTION PROGRAM REQUEST OF $106,967,000 INCLUDES $57,877,000 FOR THE CONSTRUCTION OF MEDICAL RELATED PROGRAMS. INCLUDED IN THIS REQUEST IS $4 MILLION FOR THE CONVERSION OF EXISTING BUT VACANT HOSPITAL BEDS TO NURSING HOME BEDS.

THE FY 1987 CONSTRUCTION BUDGET REQUEST IS A PRODUCT OF THE PLANNING AND DEVELOPMENT EFFORTS OF THE DEPARTMENT OF MEDICINE AND SURGERY'S PLANNING PROCESS. THE MEDICAL DISTRICT INITIATED PROGRAM PLANNING (MEDIPP) PROCESS SERVES AS THE PROGRAMMATIC CORNERSTONE OF CONSTRUCTION PLANNING IN THE VA. THROUGH THIS PROCESS, THE VA'S 27 MEDICAL DISTRICTS, USING STATE OF THE ART PLANNING TOOLS AND GUIDANCE PROVIDED FROM VA CENTRAL OFFICE, DEVELOPS PLANS TO PROVIDE NEEDED SERVICES TO THOSE VETERANS WHO USE THE VA HEALTH CARE SYSTEM. THESE PLANS, WHICH IDENTIFY AND JUSTIFY MEDICAL PROGRAMS AND LEVELS OF SERVICE ARE REVIEWED, MODIFIED (IF NECESSARY) AND APPROVED IN VA CENTRAL OFFICE. THIS SERVES AS THE BASIS FOR THE DEVELOPMENT BY EACH MEDICAL CENTER OF A FIVE YEAR FACILITY PLAN --- A CONSTRUCTION PLAN WHICH IDENTIFIES FACILITY REQUIREMENTS AND NEEDED PROJECTS TO CORRECT DEFICIENCIES AND TO PROVIDE THE NECESSARY PHYSICAL PLANT TO MEET PROGRAMMATIC OBJECTIVES. FROM THESE PLANS ARISE OUR FIVE YEAR MEDICAL FACILITY CONSTRUCTION NEEDS ASSESSMENT WHICH IS A REPORT OF THE FACILITY IMPROVEMENTS AND CONSTRUCTION REQUIREMENTS OF THE VA MEDICAL CARE SYSTEM AND IS SUBMITTED YEARLY TO CONGRESS. A MAJOR IMPROVEMENT TO OUR CONSTRUCTION

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4.

BUDGET BUILDING PROCESS IS THE NEW METHODOLOGY DEVELOPED TO ASSIST IN PRIORITIZING MAJOR CONSTRUCTION PROJECTS. THIS METHODOLOGY WHICH HAS BEEN DISCUSSED WITH THE COMMITTEE STAFF, FOCUSES ON THE PHYSICAL AND PROGRAMMATIC CHARACTERISTICS OF EACH PROJECT AND PROVIDES NUMERICAL SCORES WHICH CAN BE CONSIDERED IN ESTABLISHING PRIORITIES. THIS METHODOLOGY WAS USED TO RANK THE PROJECTS IN THE FY 1987 BUDGET PROPOSAL CURRENTLY BEFORE YOU AND WILL BE USED IN FUTURE BUDGET SUBMISSIONS, AS WELL AS IN THE DEVELOPMENT OF THE FIVE YEAR MEDICAL FACILITY CONSTRUCTION NEEDS ASSESSMENT. I WOULD NOTE HOWEVER, THAT THIS SYSTEM CANNOT AND WILL NOT SUPPLANT THE NEED FOR EXECUTIVE REVIEW BY THE CHIEF MEDICAL DIRECTOR AND THE ADMINISTRATOR TO INSURE THAT CIRCUMSTANCES AND CONDITIONS WHICH MIGHT NOT BE ADDRESSED BY THE METHODOLOGY ARE CONSIDERED IN FORMULATING AGENCY PRIORITIES. I WOULD LIKE TO SPEAK FOR A MOMENT ABOUT LONG TERM CARE. ALTHOUGH THERE ARE NO SEPARATE NEW NURSING HOME CARE PROJECTS IN OUR REQUEST, THE REPLACEMENT/ MODERNIZATION PROJECTS FOR AUGUSTA, GEORGIA AND NORTH CHICAGO, ILLINOIS WILL PROVIDE 190 NEW NURSING HOME CARE BEDS. OUR BUDGET REQUEST REFLECTS A POLICY OF MEETING VETERANS NURSING HOME CARE NEEDS PRIMARILY THROUGH THE CONVERSION OF UNDER-UTILIZED HOSPITAL BEDS IN THE MEDICAL CENTERS AND A GREATER USE OF COMMUNITY AND STATE FACILITIES. IF, HOWEVER, WE FEEL THAT IDENTIFIED LONG TERM CARE NEEDS CANNOT BE MET THROUGH CONVERSION, OR THROUGH COMMUNITY AND STATE HOME FACILITIES, NEW CONSTRUCTION WILL BE CONSIDERED. MAJOR CONSTRUCTION PROJECTS FUNDED IN FISCAL YEARS 1985 AND 1986 WILL ADD 1090 NEW NURSING HOME CARE BEDS TO THE VA'S INVENTORY. IN OUR

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5.

MINOR CONSTRUCTION REQUEST FOR FY 1987, WE HAVE INCLUDED $4.0 MILLION FOR CONVERSIONS OF HOSPITAL BEDS TO NURSING HOME CARE BEDS. AN ADDITIONAL 59 BEDS WILL BE CONVERTED TO NURSING HOME CARE USE IN FY 1987 THROUGH MEANS OTHER THAN CONSTRUCTION. IN ADDITION, OUR FY 1987 REQUEST FOR THE STATE HOME PROGRAM DOUBLES THAT PROGRAM FROM $21 MILLION TO $42 MILLION.

LASTLY, I WISH TO BRIEFLY TOUCH UPON THE PROPOSED ADMINISTRATIVE REORGANIZATION WITHIN THE VA INVOLVING THE TRANSFER OF THE OFFICE OF CONSTRUCTION TO THE DEPARTMENT OF MEDICINE AND SURGERY. THE PROPOSED REORGANIZATION WILL RESULT IN A SINGLE POINT OF RESPONSIBILITY AND ACCOUNTABILITY FOR ALL CONSTRUCTION ACTIVITIES OF THE AGENCY AND WILL ENSURE THAT THE FACILITIES UTILIZED IN THE FIELD ARE APPROPRIATELY PLANNED, DESIGNED AND CONSTRUCTED TO ENHANCE THE CARE AND SERVICE PROVIDED TO THE NATION'S VETERANS CONSISTENT WITH THE ECONOMICAL USE OF RESOURCES.

MR. CHAIRMAN, I WOULD LIKE TO THANK YOU FOR THE OPPORTUNITY TO APPEAR HERE TODAY AND MY STAFF AND I WOULD BE PLEASED TO ANSWER QUESTIONS THAT YOU OR THE OTHER MEMBERS MAY HAVE.

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DEFERRED MEDICAL CONSTRUCTION PROJECTS

The following major medical construction projects were considered for inclusion in the FY 1987 budget submission but due to budget constraints were deferred:

VAMC	Project	($000)
Asheville, NC	120-Bed Nursing Home Care Unit	$ 6,400
Atlanta, GA	Clinical, Parking, Seismic (Design)	$ 7,200
Dallas, TX	Clinical Addition, Renovate Building 2, Spinal Cord Injury Center (Design)	$14,300
Fayetteville, NC	120-Bed Nursing Home Care Unit	$ 6,800
Hampton, VA	112-Bed Nursing Home Care Unit Addition	$ 5,700
Huntington, WV	Clinical Improvement Addition	$48,000
Knoxville, IA	Laundry Replacement	$ 5,200
Marion, IN	240-Bed Nursing Home Care Unit	$11,600
Martinsburg, WV	Laundry Replacement	$ 5,600
Montgomery, AL	Outpatient and Ward Renovations	$26,000
Mountain Home, TN	120-Bed Nursing Home Care Unit	$ 6,500
New York, NY	Outpatient Clinical Addition/ Renovation	$76,600
North Chicago, IL	120-Bed Nursing Home Care Unit	$ 7,800
Palm Beach, FL	New Medical Center	$10,000
Pittsburgh (ASP), PA	Replacement Medical Center (Design)	$ 5,300
Salt Lake City, UT	30-Bed SCI and Canteen	$15,000
Tampa, FL	120-Bed Nursing Home Care Unit	$ 6,000
Wilmington, DE	Clinical Addition	$32,000

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DM&S WESTERN REGION
MISSION CONVERSION RECOMMENDATIONS
VAMC WALLA WALLA, WASHINGTON

BACKGROUND:

The situation surrounding the continued operation of VAMC Walla Walla, Washington has been formally and informally discussed within Medical District 27 (the Pacific Northwest) since at least the early 1970's. In 1981, the VA instituted a formal decentralized planning process known as MEDIPP (Medical District Initiated Program Planning). Although MEDIPP was established as a strategic planning mechanism, its application was partly to identify cost-saving opportunities in an emerging decremental budgetary environment.

During the 1985 MEDIPP planning cycle, each medical district was asked to update their planning strategies based on three different recurring budget scenarios (a 5% increase, a 5% decrease or a no change scenario). In analyzing strategies for a negative 5% budget scenario, Medical District 27 determined that a mission conversion for VAMC Walla Walla would be the most appropriate course of action. This was based on analysis of inpatient workloads, veteran population served, services provided, and the capital and operating resources required to maintain services. The Western Region Planning Board, in reviewing the district's recommendation for VAMC Walla Walla, determined that the district's analysis supported recommending a mission conversion as a matter of strategic policy.

WHAT IS BEING RECOMMENDED:

The mission conversion proposal would entail closing all inpatient beds. There is a total authorized bed capacity at Walla Walla of 87 medicine, 26 surgery and 37 psychiatry beds. The hospital is presently operating 62 medicine, 20 surgery and 37 psychiatry beds. A VA outpatient facility would be maintained. During FY 1985, there were a total of 26,208 outpatient visits.

WHAT IS THE RATIONALE FOR THE RECOMMENDATION:

There were many factors which were taken into consideration by the medical district and region in developing the mission change proposal, including: 1) a very low (and declining) volume of inpatients treated, 2) a very low percentage of service-connected veterans treated, 3) the geographic dispersal of the veteran population in the Walla Walla service area, 4) the need for a major capital expenditure to maintain acute care services (a $24 million replacement facility), and 5) current and projected VA budget constraints.

WHAT IS THE CURRENT STATUS OF THE RECOMMENDATION:

The result of the district and regional deliberations was a draft Regional Plan which was submitted to VA Central Office on December 1, 1985. This plan is now being assessed in the national review process, along with planning initiatives from other parts of the VA system. Final decisions from the VA Chief Medical Director and Administrator are not expected for several more months.

The Medical District, through the MEDIPP process, will continue to evaluate other potential uses for the present site. Such considerations in the past have included the possibility of a State veterans facility or a VA Nursing Home Care Unit. As part of the MEDIPP constituency awareness policy, a summary of the draft District 27 planning initiatives was distributed to various various constituency groups in the Walla Walla area. A community meeting was held in Walla Walla on March 17, 1986 to solicit comments and answer questions about the plan.

VA REQUEST

CONSTRUCTION - MAJOR PROJECTS
PROGRAM DESCRIPTION AND DETAIL OF REQUEST

A program level of $358,208,000 is requested for the construction projects listed below. The program will be funded by reprogrammings from prior appropriations in the amount of $57,000,000 and by new budget authority of $301,208,000.

Location	Description	Total Estimated Cost	Available Thru 1986	1987 Request	For Future Consideration
			(dollars in thousands)		
A. Medical Program:					
Replacement and Modernization:					
Augusta(Uptown Division), GA	Replacement Medical Center	$ 97,000	$12,400	$ 84,600	...
Baltimore, MD	Replacement Medical Center	121,000	10,800	110,200	...
Dayton, OH	Bed Replacement and Modernization	84,000	...	8,400	$75,600
North Chicago, IL	Environmental Improvements, Patient and Nursing Home Care Buildings	92,000	...	9,200	82,800
	Subtotal	394,000	23,200	212,400	158,400
Research and Education:					
White River Junction, VT	Research and Education Building	9,300	...	9,300	...
	Subtotal	9,300	...	9,300	...
Other Improvements:					
Advance Planning Fund:					
Various Stations		5,000	...	5,000	...
	Subtotal	5,000	...	5,000	...
Asbestos Abatement:					
Various Stations		9,908	...	9,908	...
	Subtotal	9,908	...	9,908	...
Clinical Improvements:					
Salem, VA	Outpatient, Clinical and Nursing Unit Addition	66,300	...	66,300	...
Salisbury, NC	Geropsychiatric Building	19,000	...	19,000	...
	Subtotal	85,300	...	85,300	...
Minor Fund:					
Various Stations		19,000	...	19,000	...
	Subtotal	19,000	...	19,000	...
Electrical Improvements:					
Salt Lake City, UT	Electrical Distribution	6,600	...	6,600	...
	Subtotal	6,600	...	6,600	...
Fire and Safety Improvements:					
Milwaukee(Wood), WI	Fire and Safety Improvements	8,400	...	8,400	...
	Subtotal	8,400	...	8,400	...

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CONSTRUCTION - MAJOR PROJECTS (Continued)
PROGRAM DESCRIPTION AND DETAIL OF REQUEST

Location	Description	Total Estimated Cost	Available Thru 1986	1987 Request	For Future Consideration
		(dollars in thousands)			
General Projects:					
Waco, TX	Renovate Buildings 10 and 90	$9,700	...	$9,700	...
	Subtotal	9,700	...	9,700	...
Subtotal, Major, Department of Medicine and Surgery		$547,208	$23,200	$365,608	$158,400
B. National Cemetery Program:					
Various Stations	Design Fund	600	...	600	...
Subtotal, Major, Department of Memorial Affairs		600	...	600	...
Subtotal, Construction Program Level Request, Major Projects		$547,808	$23,200	$366,208	$158,400
Less: FY 1986 Design Fund 1/		- 8,000	...	- 8,000	...
Total, Construction Program Level Request, Major Projects		$539,808	$23,200	$358,208	$158,400

1/ This amount represents ... technical services funded from the Design Fund that are included in the individual project's total estimated costs.

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STATEMENT OF HON. MICHAEL BILIRAKIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Thank you, Mr. Chairman.

I want to join you in welcoming Dr. Ditzler and our other witnesses here this morning and I certainly look forward to their testimony.

I want to take a moment to express my support for the Committee's recommendations to the Budget Committee regarding the VA's FY 1987 budget. Unfortunately, a scheduling conflict caused me to miss last week's vote.

I am participating in a series of very important hearings in the Senate on the issue of live sightings of Americans still being held in Southeast Asia as a follow-up to a trip I made to Vietnam and Laos in January with Chairman Murkowski, Senator Deconcini and Congressman McEwen.

We were questioning Administration witnesses about government actions to confirm the presence of live Americans and secure their release at the same time this Committee was voting on its budget recommendation. I am confident that my fellow Committee members and my fellow veterans share my commitment to gaining the fullest possible accounting for all American POWs and MIAs and I felt it was important to stay at the Senate hearing.

Nevertheless, I strongly support the Committee's action and would have voted for approval of the recommendations made. I was particularly pleased that the Committee recognized the tremendous needs we have in the State of Florida and voted to restore funding for the new VA hospital in Palm Beach County and a nursing home unit at the Haley Hospital in Tampa.

However, I remain concerned about the slippage of the clinical care addition/Spinal Cord Injury Unit project in Tampa from the VA's 1987 budget and hope I will have the opportunity during questioning to ask Dr. Ditzler about this change in priorities.

Thank you, Mr. Chairman.

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VETERANS' AFFAIRS COMM.TTEE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
MARCH 6,1986

STATEMENT OF DAN MICA FOR THE RECORD

I would first like to thank Dr. Ditzler, and representatives of the Veterans' Administration, VFW, AMVETS, DAV, American Legion, and PVA for coming before us today to discuss the VA budget for 1987.

I do want to emphasize the great need that still exists in Florida for new VA medical facilities. All of the evidence points to a continuing increase in the veterans population in Florida, with a significant increase in older veterans over the age of 65. There has been absolutely no evidence to suggest that the numbers of veterans has or will decrease in Florida.

I am pleased that this committee has replaced funding for the Palm Beach County medical center. This action is in keeping with the VA's recommendations contained in both the "Thirty Year Study of the Needs of Veterans in Florida", and the "Five Year Medical Facility Construction Needs Assessment".

In closing, I would just like to thank the Veterans' Administration for their cooperation in our efforts to provide the highest quality of care for our veterans, and I would like to thank the members of this committee for their bipartisan support for these efforts. The care for our veterans can not and will not be compromised in an attempt to arbitrarily cut expenses.

Statement of

The American Legion

1608 K STREET, N. W.
WASHINGTON, D. C. 20006

by

PAUL S. EGAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

and

JOHN F. SOMMER, JR., DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

on

VETERANS ADMINISTRATION MEDICAL CONSTRUCTION

March 6, 1986

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STATEMENT OF JOHN F. SOMMER, JR., DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 6, 1986

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates this opportunity to offer its views on the Veterans Administration's construction authorization request for FY 1987.

At the outset Mr. Chairman, we would like to take this opportunity to thank you, Chairman Montgomery, Ranking Minority Member Mr. Hammerschmidt, and the Members of the full Committee for the report of February 27, wherein it was proposed to the Committee on the Budget that $23 million in budget authority and outlays be added to the FY 1987 VA Budget for the construction of nursing homes at Tampa, Florida and Hampton, Virginia; design funds for the clinical addition at the Aspinwall VA medical center, and funds for site acquisition of a hospital at Palm Beach, Florida.

This recommendation is a significant improvement over the Administration's proposal of $415.5 million, which reflects a reduction of $331.9 million from the current fiscal year.

As we have stated for the past several years, it is just not wise to drastically reduce the funding for medical construction when the capital plant of the VA health care system is deteriorating. It seems that the Office of Management and Budget has it in mind to allow the system to continue to deteriorate through underfunding of the renovation and replacement program, which is one of the primary reasons for the current state of degeneration.

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What happens then? Is it OMB's intention to reduce the system until there is none?

The American Legion believes very strongly that it is important to maintain the capital plant of the VA medical care system, and that adequate funding must be provided to upgrade and replace existing facilities.

It is obvious that the Veterans Affairs Committee shares this commitment, and the Committee's recommendation to include funding for the four projects that were previously mentioned is sincerely appreciated by The American Legion.

The projects that are included in the Administration's major construction proposal are a replacement medical center in Baltimore; a replacement medical center in Augusta, GA; bed replacement and modernization at the Dayton, Ohio VAMC; fire and safety improvements at Wood, WI; environmental improvements, patient and nursing home care buildings at North Chicago; outpatient, clinical and nursing unit addition, Salem, VA; geropsychiatric building, Salisbury, NC; electrical distribution, Salt Lake City; renovate buildings 10 and 90, Waco, TX; and a research and education building, White River Junction, VT.

We must say that we are extremely pleased that the Administration has finally come around to the point of view that has been espoused by The American Legion since the mid 1970's with respect to the need for a replacement hospital in Baltimore.

We are extremely concerned about the Administration's "plan for the future" that dictates no new independent nursing home care unit construction, and greater reliance on community nursing homes. The

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nursing care formula currently in use consists of 40 percent VA, 40 percent State Homes and 20 percent private sector nursing homes. The new plan calls for 30 percent VA, 40 percent State Homes, and 30 percent private sector facilities.

This proposal of a new long-term care policy that emphasizes the use of community nursing homes is not really a new concept. The American Legion has opposed this idea in the past for several very good reasons. We do not disagree that community nursing homes play an important role in VA's effort to provide nursing care to veterans. However, there are certain postulates that must be taken into consideration.

It has been stated by some that the costs of constructing and operating VA nursing home care units are higher than those in the private sector. It must be realized that these government owned and operated facilities have vigorous obligations placed upon them to provide optimum quality medical care to veteran patients. Ongoing oversight is provided by the Congress, The American Legion and other veterans organizations, and by the VA itself through its Professional Services. Community nursing homes are not subjected to such thorough and constant policing. In addition, the VA nursing home patient load has a high percentage of veterans who because of the care they require are frequently not acceptable to community nursing homes. Veterans in VA nursing home care units are usually sicker and stay longer than individuals in private sector nursing homes and, therefore, they require more specialized facilities and equipment for their care. The community nursing homes

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are commercial ventures and many times refuse such cases because they are not profitable.

An additional factor that must be considered is the lack of availability of community nursing home beds in some areas. There exists across the country an unequal distribution of long-term care resources. The availability of nursing home beds in some instances even varies in different parts of a State. An example of existing need is Providence, Rhode Island, where we have supported the construction of a 60-bed nursing home for several years. This is but one example of why we are thoroughly convinced that it is not a good idea for the Veterans Administration to cease construction of nursing home care units.

As for the replacement and renovation projects scheduled for FY 1987, based on the reports of our Field Representatives who make site visits to all of these facilities, we can assure the Subcommittee all of the work scheduled is needed, and much of it is long overdue.

However, it is distressing to see that only two replacement hospitals are included in this projection. The Office of Management and Budget is only fooling itself by delaying the funding for badly needed projects. This is false economy, pure and simple and will end up costing more in the long run, rather than saving the Government money, because the longer the projects are delayed the more it will cost to build them. And in the meantime the capital plant continues to decay.

Allowing this system to deteriorate makes no sense at all and, in fact, contradicts the Administration's position on national defense when one considers that VA medical centers constitute the

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principal contingency resource to treat returning casualties during a national wartime emergency.

It is obvious to The American Legion that Congressional intervention is the only possible solution to this abominable situation, and fortunately the Veterans Affairs Committee has initiated a move in that direction.

Mr. Chairman, we also appreciate the Committee's recommendation to the Budget Committee that certain land at the Sepulveda, California VAMC, and 109 acres of land that are presently part of the complex that includes the VAMC West Los Angeles, not be declared excess to the needs of the Veterans Administration.

The entire complex that comprises VAMC West Los Angeles, VAMC Brentwood, the VA Domiciliary and the National Cemetery operated by the VA Department of Memorial Affairs includes a total of 545.5 acres.

The original grant of the land that comprises these various VA activities was made in a deed executed by the owners of the land in the year of 1888. The land was gifted by the owners to the Federal Government to be used for the construction and operation of a Home for Disabled Volunteer Soldiers. Such a home was constructed and maintained, and through the years the original activity has changed, expanded and been modified until we see that today the entire complex comprises a variety of activities carried on by VA for veterans.

As the City of Los Angeles has expanded the land comprising the VA complex at West Los Angeles has become exceedingly valuable real estate. We can attest that all the VA land is coveted by the City of Los Angeles, by the University of California at Los Angeles

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(UCLA), and by developers who could make millions of dollars if they could gain control of that land, or any part of it.

The American Legion of California has long entertained an apprehension, shared by the National Organization of The American Legion, that sooner or later a move would be made to attempt to gain control of some or all of this land, as it is described in these paragraphs. We see in this initiative to transfer 109 acres of the land to GSA, the first move in this direction. The value of the land in Los Angeles County being what it is, and human avarice being what it is, there is no way some move would not be made to dispossess sick and disabled veterans from such valuable land to the end of putting a lot of money in somebody's pocket - here we refer to developers.

If the transfer proposed in this budget initiative is accomplished, we of the Legion have reason to believe that the heirs and descendants of the owners who gave the land to the U.S. for the specific purpose of caring for sick and disabled veterans may very well undertake court action to invalidate the original deed and reclaim the entire complex of land. The resulting value of such an action, if successful, would be profitable to the claimers beyond the wildest imagination of most of us.

The American Legion will continue to oppose the transfer of any portion of the land herein discussed to anybody, for any purpose other than to continue to provide care for veterans. We petition this Subcommittee that the first thing that must be done is to obtain from appropriate legal authority an opinion on the language of the original deed of transfer of 1888, and an interpretation of the legal

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authority the United States may have, or may not have, to dispose of any portion of the land included in the original deed of transfer.

In addition to that, we wish to state for the record that the complex of land described herein encompasses a wide variety of activities for the care of perhaps the largest single concentration of veterans to be found in the nation. There is no possibility that the scale of veterans activities now being carried on at West Los Angeles will be in any way scaled down for the foreseeable future.

Mr. Chairman, thank you for this opportunity to express the views of The American Legion.

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VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT OF

DENNIS M. CULLINAN, SPECIAL ASSISTANT
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VETERANS ADMINISTRATION MEDICAL CONSTRUCTION AUTHORIZATION REQUEST

WASHINGTON, DC MARCH 6, 1986

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for this opportunity to present the views of the Veterans of Foreign Wars of the United States with respect to the construction authorization for the Veterans Administration's Department of Medicine and Surgery. The VFW is appreciative of the Chairman for holding this hearing, demonstrating his and the Subcommittee's ongoing concern for the current and future health care needs of our Nation's veterans.

The VFW is very alarmed at the Administration's proposed construction budget for the VA's Department of Medicine and Surgery for fiscal year 1987 of only $408 million in new budget authority. This is a reduction of over $208 million from fiscal year 1986 and clearly demonstrates that, in order to save a few dollars, the Administration is willing to forsake this Nation's moral commitment to provide high-quality health care to its veterans now that the need is on the rise.

★ WASHINGTON OFFICE ★
VFW MEMORIAL BUILDING ● 200 MARYLAND AVENUE, N.E. ● WASHINGTON, D. C. 20002 - 5799 ● AREA CODE 202 543-2239

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As we all know, the entire American population is growing older on the average; however, the growth in the number of aging veterans is much more rapid. By 1990, veterans over the age 65 will make up more than one-fourth of the veteran population and by the year 2000 will have reached slightly over one-third. Further, the number of "frail elderly," those 75 years of age and older, in the veteran population will increase more than fourfold by the year 2000.

It is now well understood that older people have more and different health problems than are seen in younger individuals. Older people have more sicknesses and episodes of illness are often perpetuated by pre-existing chronic conditions or by slow response to treatment. Thus, the rapidly aging veteran population is placing a tremendous demand on all of the VA's resources and particularly its physical plant.

Considering that the health care needs of the aging veteran population will continue to increase and place an ever greater demand on the VA's delivery system, the Administration's proposed reductions in the VA's medical care construction authorization would serve to exacerbate a situation which is already critical and demonstrates what is, to our minds, a profound lack of sound judgment or commitment or both. The proposed authorization for fiscal year 1987 for the replacement and modernization activity is only about $212 million. This is a reduction of almost $189 million from fiscal year 1986 and would mean that the VA could not maintain even its current physical structures. This particular area has suffered for years from under-funding and, for this reason, the VA is already unable to satisfactorily answer the needs of the veteran population. This is born out inasmuch as 37,000 veterans a month are being denied health care at this time. Fifty-three percent of all VA beds are housed in buildings which are 30 or more years old. It can readily

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be seen that, unless the construction program is quickly and substantially enhanced, the shortage of space will rapidly worsen. Reducing this program--as is being proposed by the Administration--would spell disaster.

In this regard, it is inconceivable to us that the Administration would propose reducing the authorization for VA nursing home construction from $22.5 million in fiscal year 1986 to only $4 million in fiscal year 1987. This paltry funding level will result in all new VA nursing home projects being cancelled.

Similarly, it may only be viewed as appalling that no new funding is to be provided in fiscal year 1987 for VA domiciliaries. This is the sorry consequence of a new Office of Management and Budget [OMB] mandated policy which directs the VA to shift the responsibility for VA nursing home care to state and community facilities. This OMB policy is especially callous in light of the fact that the need for such facilities is now sharply on the rise and that state and community resources in this area are already overburdened. A sudden large influx of elderly veterans into these systems could well occasion their total collapse.

The VFW applauds the proposed increase of over $21 million in budget authority for grants for construction of state extended care facilities which would set the authority for this program for 1987 at over $42 million. We appreciate that this would assist the VA in reducing the number of backlogged applications on hand from the states and should result in more extended care beds being available sooner.

Even so, we would point out that such a large increase in funding may result in the inefficient utilization of precious funds. One problem is that states are often hard put or reluctant to secure the necessary funding for building such facilities even with the availability of federal money. Further, it is also apparent that the Administration and OMB, through pursuing such a course, are attempting to escalate the privitization of veterans' health care. This, to our

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minds, will very swiftly result in fewer and fewer veterans being provided with less and less health care. What is more, it is our fear that this unscrupulous push toward the wholesale privitization of veterans' health care is a ploy to transform this Nation's largest integrated health care system into a mere bureaucracy tasked only with the dispensing of vouchers and the cursory orchestration of very meager veterans' services.

With this in mind, we point with alarm and grave concern at the proposed diminishment of the VA's major construction activities funding along with the proposed reduction of over $24 million in its minor projects' authorization. In sum, such a low level of funding would constitute a severe blow to the VA's health care system and a slap in the face to this Nation's veterans.

Mr. Chairman, a germane resolution adopted by the voting delegates to our most recent National Convention is appended to my testimony.

Thank you and I will be happy to respond to any questions you may have.

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Resolution No. 717

VETERANS' HEALTH CARE

WHEREAS, Congress on July 21, 1930, established the Veterans Administration health care system and progressively increased their responsibilities to administer veterans' benefits; and

WHEREAS, attempts are now being made to drastically alter and reduce veterans health care (long and short term) benefits through budgetary constraints such as "mainstreaming" veterans away from veterans facilities into the private sector; barring veterans with nonservice-connected disabilities from eligibility or eliminating construction and maintenance of hospitals, domiciliaries, nursing care homes/units; reimbursing the VA from third parties; reducing VA staff and regionalizing; and

WHEREAS, the VA cuts in the health care system will not only affect the veterans, but also their dependents and all political, economic and social lines; and

WHEREAS, with the demographic increase of the aging veteran population plus younger veterans, the quality of comprehensive health care in a VA facility is unparalleled, and is no more expensive than other federal health care programs and less expensive than private systems to care for all needy veterans (long and short term); now, therefore

BE IT RESOLVED, by the 86th National Convention of the Veterans of Foreign Wars of the United States, that we support maintaining federal funding for the VA health care system benefits for ALL veterans, plus increasing VA health care facilities (hospitals, domiciliaries and nursing care homes/units) to provide long and short term care due to the increasing needs of the aging and younger veterans.

Adopted by the 86th National Convention of the Veterans of Foreign Wars of the United States held in Dallas, Texas, August 16-23, 1985.

Resolution No. 717

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STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
March 6, 1986

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the over one million members of the Disabled American Veterans and its Ladies' Auxiliary, I would like to take this opportunity to thank you and the members of the Subcommittee for allowing us the opportunity to present our views on the Veterans Administration's medical construction program budget request for Fiscal Year 1987.

Before specifically addressing the VA's proposed Fiscal Year 1987 construction request, Mr. Chairman, we believe that it is important to place the Veterans Administration medical care program -- Department of Medicine and Surgery (DM&S) -- in its proper context to the delivery of health care, in general, and to veterans, in particular.

The stated mission of DM&S is "to ensure that quality medical care is provided on a timely basis within the law to all authorized veterans."

This mission is formulated to provide:

* a complete medical and hospital service for the medical and hospital care of veterans;

* a program of education and training of health care personnel;

* a program of medical research; and

* health care services to members of the Armed Services during war or national emergency.

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Medical Services

Presently, Mr. Chairman, the VA's health care system is comprised of 172 medical centers, 227 outpatient clinics, 110 nursing home units and 16 domiciliaries.

Within current statutory framework, the VA is authorized to furnish medical treatment to:

1. any veteran for a service-connected disability;

2. any veteran (for any disability) who has a service-connected disability rated at 50% or more;

3. former prisoners-of-war;

4. veterans entitled to nonservice-connected pension;

5. World War I, Spanish American War and Mexican Border Period veterans;

6. Vietnam veterans exposed to certain herbicides, i.e., Agent Orange;

7. veterans exposed to ionizing radiation (atomic veterans);

8. any veteran 65 years of age or older for a nonservice-connected disability; and

9. any veteran for a nonservice-connected disability if unable to defray the costs of necessary treatment.

Contrary to the varied assertions voiced by a variety of individuals and sources, the VA medical care system has, is, and will continue to treat veterans who are, in the vast majority, service-connected and/or medically indigent. Only one in nine veterans -- slightly more than 10% of the estimated 28 million living veterans -- have ever availed themselves of VA medical care.

Mr. Chairman, it seems abundantly clear, for a variety of reasons, that the VA is correct in its estimation that of the 12 million veterans (service-connected, those in receipt of

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nonservice-connected pension, those age 65 or over, or those who are unable to defray the cost of private medical care) eligible for VA medical care and treatment, only a portion will access into the system during their lifetime.

Clearly, fiscal constraints and finite federal dollars, in conjunction with established priorities and the freedom of choice of some veterans to receive medical care elsewhere, have dictated and will continue to dictate how many veterans enter the system.

The VA will treat, on an inpatient basis, an estimated 1,247,667 veterans in Fiscal Year 1987, representing a decrease of some 58,000 from Fiscal Year 1986. Approximately 22,300 veterans (an increase of only 733) will be treated in VA nursing home care units while maintaining an average daily census of 10,972 (an increase of only 380) over 1986 levels. Additionally, 16,676,000 outpatient medical visits are estimated to occur in Fiscal Year 1987 (a decrease of over 1.1 million from the Fiscal Year 1986 level).

Mr. Chairman, from Fiscal Year 1976 ($3.7 billion) to Fiscal Year 1986 ($9.4 billion), the VA health care budget has more than doubled in total actual dollars. However, once deflated to reflect movement in the Consumer Price Index, we view a virtually solid straight-line budget.

Additionally, a comparison of VA health care dollars as a percent of the total federal outlays for health, medicine and veterans hospital and medical care reveals a decline from 11.4% of total outlays in Fiscal Year 1977 to an estimated 8.5% in Fiscal Year 1987.

On average, VA patients are older, have lower incomes, have less health care insurance, and are often in need of specialized and more comprehensive type care than their counterparts in the

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general population. Also, VA inpatient services are intrinsically linked to outpatient services and specialized modalities of treatment.

The above, Mr. Chairman, illustrates, albeit briefly, the general scope, responsibility and workload encompassed in the VA medical care program. Suffice it say, that the VA's Department of Medicine and Surgery is the nation's largest integrated comprehensive, total medical care system in the country. It is the only system capable of providing a full array of health care services to this nation's eligible, disabled veterans.

Education and Training

Mr. Chairman, each year nearly 100,000 students receive some or all of their clinical training in VA facilities through active affiliations with over 1,000 educational institutions.

In Fiscal Year 1984, the VA supported approximately 7,800 full time medical residency positions under affiliations with 101 medical schools. Special emphasis was given to supporting programs in psychiatry, anesthesiology, geriatrics, radiology and physical medicine and rehabilitation. Through similar arrangements, VA facilities also provided clinical education experience for undergraduate medical students.

To meet the special needs of veterans and to provide national leadership in the areas not adequately addressed by existing training programs, specialist physician fellowship programs exist within the VA. These include fellowship programs in geriatrics, spinal cord injury, substance abuse and geriatric dentistry.

It is clear, Mr. Chairman, that the VA conducts the health profession's largest coordinated education and training program in the country.

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Research and Development

Mr. Chairman, the VA's research and development programs continue to make significant contributions toward fulfilling the VA's charge to provide veterans with the best possible health care. These contributions have been made possible by a long-standing policy of linking VA medical centers with major medical schools and encouraging clinical and non-clinical investigators to study the wide variety of health care issues prevalent to veterans.

The VA's medical research service has been instrumental and remains active in creating new medical knowledge and breakthroughs in such areas as treatment of mental illness, hypertension, kidney disease, the effects of aging, spinal cord injuries, tissue regeneration, health problems of female veterans and former prisoners-of-war and the effects of exposure to Agent Orange and post-traumatic stress disorders primarily among Vietnam veterans.

Mr. Chairman, the mission of the Rehabilitation Research and Development (RR&D) Service is to improve the quality of life for impaired, disabled and handicapped veterans by making them more functionally independent. This mission has been significantly advanced by ongoing research and development projects in established priority areas of prosthetics/amputation, spinal cord injury and sensory aids.

Major, ongoing research is being conducted in the areas of developing a new generation of artificial limbs that will be lighter, better fitting and more functional to permit greater natural movement and participation in a wider variety of vigorous activities for amputees.

The use of robotics and computer controlled electrical stimulation to restore some function to paralyzed limbs are

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constantly being explored in order to make the spinal cord injured veteran more independent.

The development and practical utilization of advanced aids for the blind and hearing impaired veteran are also high priority areas that the VA is engaged in with promising findings and results being noted.

The Health Services Research and Development (HSR&D) Service is dedicated to improving veterans' health care by evaluating alternative medical interventions and policies that enable VA clinicians and administrators to make intelligent and efficient health care decisions and choices.

It has recently come to our attention, Mr. Chairman, that a decision has been made to transfer the functions of HSR&D from the Assistant Chief Medical Director for Research and Development to the office of the Assistant Chief Medical Director for Planning, Coordination and Systems Development.

The DAV has not been officially advised by the VA of the planned transfer of functions. Therefore, we do not wish to comment specifically at this time.

We do, however, want to offer our opinion that HSR&D activities, both in Central Office and its field programs, have contributed significantly to the VA's ability to provide quality medical care.

Mr. Chairman, our major concern is that HSR&D will be able to continue to function and engage in meaningful projects that will further enhance the VA's ability to provide quality and efficient health care.

It can be accurately stated that the VA's medical, rehabilitation and health services research efforts

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have helped the VA keep pace with and, in many instances, set the standards for modern, quality health care in this country.

Veterans Administration/Department of Defense
Health Resources Sharing Program

As you are aware, Mr. Chairman, Public Law 97-174, the -- Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act -- mandates the VA to serve as the primary health care back up to the Department of Defense (DOD) in the event of war or national emergency. Additionally, this Act provided new and expanded opportunities for the sharing of health care resources between VA and DOD.

At the end of Fiscal Year 1985, 201 sharing agreements were in effect between the VA and military hospitals. Ninety-two military medical facilities had entered into at least one agreement with 79 VA medical centers.

The scope of sharing agreements include cardiac and a variety of other surgical services, a vast array of inpatient and outpatient general medical services, treatment of spinal cord injuries, pathology, dietetics and dental service.

Additionally, many non-direct patient care services are performed on a sharing basis to include laundry and library services.

Mr. Chairman, in our opinion, the delivery of quality health care to this nation's disabled veteran population entails a commitment to modern, safe and efficient medical care facilities.

To fulfill this commitment, it is necessary that the VA provide, on an continuing basis, for the reasonable expansion, renovation, modernization and replacement of its medical facilities.

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To do less, Mr. Chairman, would, in our view, jeopardize and ultimately dismantle the VA system. Without active affiliations in programs of education, training and research efforts -- which serve as highly successful vehicles to attract quality health care providers -- the quality of care provided by the VA would not exist to the potential necessary to make the system viable.

The Congressional mandate that the VA act as the primary source of medical care back up to the Department of Defense would be, for all practical purposes, nullified absent medical construction funds to maintain the physical plant facilities of the VA's approximate 5,000 separate buildings.

Fiscal Year 1987 Construction Budget

As you know, Mr. Chairman, the VA's Fiscal Year 1987 program level request for construction is $465 million, some $332 million below the Fiscal Year 1986 level. The proposed budget would reduce funding for medical facility construction by approximately 41% from the Fiscal Year 1986 budget, a decrease of $208.4 million ($184 million in major projects and $24 million in minor projects).

Of the total program level, approximately $423.5 million will be devoted to the health care system.

Highlights of the medical construction program include:

* $212.4 million for replacement and modernization projects;

* $44.7 million for general and miscellaneous projects to accomplish certain renovations, modifications, remodeling and other general improvements for support systems;

* $94.6 million for clinical improvements;

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* $10.4 million for fire and safety improvements;
* $4 million for nursing home improvements;
* $1.5 million for outpatient improvements;
* $19 million for the design fund; and
* $5 million for the advanced planning fund.

Mr. Chairman, a review of the VA's Fiscal Year 1987 construction request for medical programs reveals that the agency's ability to provide quality care is being placed in jeopardy.

Simply stated, while we support full funding of the proposed construction program, we are nevertheless concerned, not only with the quality of care currently being provided, but also about the VA's ability to meet the pressing demands being placed upon the health care system.

The DAV is concerned, as I know you are, Mr. Chairman, with how the VA will provide quality health care to the rapidly increasing aging veteran population.

According to VA statistics, there were three million veterans age 65 and older in 1980, constituting 10.5% of the total veteran population. By 1990, this figure is expected to rise to 7.2 million, representing 26.6% of the total and by the year 2000, the number will reach nine million, translating to 37% of the veteran population.

We know that greater numbers of elderly veterans are seeking nursing home care from the VA, yet, of this medical construction budget, less than 1% ($4 million) is requested for nursing home care bed construction, conversion, renovation and relocation.

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Furthermore, while more and more elderly veterans are seeking nursing home care from the VA, this construction request reflects a new OMB mandated policy which directs the VA to shift the responsibility for VA nursing home care to state and community nursing facilities. As a result, all new VA nursing home projects have been proposed to be cancelled.

We do support the VA's proposal to convert 59 hospital beds to nursing home care beds. However, as demand for nursing home care beds rapidly increases, we would urge the VA to direct greater attention to the conversion of beds already closed (or to be closed) to nursing home care beds. While the VA is considering the conversion of these few acute care beds within hospitals, we view their future plans to be directed more at a change of mission, i.e., conversions of entire hospitals.

Mr. Chairman, the DAV will not, in every instance, oppose the VA's plans to change the mission of certain VA hospitals. However, as the demand rapidly increases for nursing home care beds, we would urge the VA to proceed on a swift timetable concerning conversion of beds, while maintaining an appropriate balance to meet the acute and intermediate health care needs of all veterans, including the aging veteran.

Mr. Chairman, OMB and the VA have clearly circumvented the law (Section 5010(a)(1), Title 38, United States Code). In Fiscal Year 1986 the VA will operate with 1,800 fewer beds than that which is required by law and it is projected that in Fiscal Year 1987 bed levels will drop 4,000 below statutory requirements.

The DAV has an inherent interest in the maintenance of VA hospital beds for the care and treatment of all eligible veterans. Yet, the Fiscal Year 1987 budget projects the loss of 2,700 hospital beds. This reduction will bring the total loss of hospital beds within the confines of the system to 5,900 since 1992. Conversely, the VA has added only 2,600 nursing

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home care beds to the system over the same period, a net loss of 3,300 beds since 1982.

As you know, Mr. Chairman, the Medical District Initiated Program Planning (MEDIPP) is used as a plan to assess the system's future needs based upon a medical district prospective and the shift in veteran population.

Additionally, MEDIPP is capable of assisting in the construction program by integrating grass roots, programmatic planning; developing early conceptualization of facility construction needs; and by expanding the flexibility of space criteria to meet changes in mission requirements.

Mr. Chairman, the DAV supports the facility planning concept embodied in MEDIPP -- making the most cost-effective use of resources and funding that is available. The program should continue to provide input in the construction planning process.

The VA's Fiscal Year 1987 construction request includes $5 million for the Advanced Planning Fund (APF). As we understand it, the APF is designed to provide flexibility to explore various corrective strategies, propose alternative conceptual approaches and enable informed decisions to be made.

Additionally, the VA is requesting $19 million in Fiscal Year 1987 for the design fund. This fund, with certain restrictions, permits the VA to initiate working drawings for construction projects prior to final Congressional approval for funding. By using this process, the VA estimates an average delay of 15 months may be eliminated, thereby producing savings to the VA by the avoidance of additional inflationary cost.

Mr. Chairman, if in fact the flexibility provided by the APF is present and beneficial and taxpayer dollars are saved by eliminating unwarranted delays as suggested by the mechanics of

the design fund, then the DAV can support full funding of these items in the construction budget.

Grants for Construction of State Extended Care Facilities

As you are aware, Mr. Chairman, this program provides grants to assist states to acquire or construct state home facilities for furnishing domiciliary or nursing home care to veterans and to expand, remodel, or alter existing buildings for furnishing domiciliary, nursing home or hospital care to veterans in state homes.

Under the current program, a grant may not exceed 65% of the total costs of the project and grants to any one state may not exceed one-third of the amount appropriated in any one fiscal year.

The VA's Fiscal Year 1987 appropriation request of $42.4 million will provide for an additional 120 nursing home, 126 convertible and 150 docmiciliary beds.

Without question, Mr. Chairman, the domiciliary, nursing home and hospital care provided to this nation's veterans by state veterans homes has been invaluable in terms of offsetting the severe losses suffered by the VA's health care system as discussed earlier.

During Fiscal Year 1986, state veterans homes will maintain an estimated average daily census of 8,434 nursing home, 4,516 domiciliary, and 512 hospital patients. In Fiscal Year 1987, state nursing homes', domiciliaries' and hospitals' average daily census is projected to increase by 402, 68 and 5, respectively.

Recognizing the significant and important role of state veterans homes -- in terms of care provided to the rapidly aging

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veteran population and the cost effective use of federal taxpayer dollars that supplement this program -- we believe it is indeed wise to continue funding this program that ultimately produces savings to the government in terms of both construction and health care costs.

The DAV has always been supportive of the VA's medical construction program. However, the fact is that the capital plant of the VA health care system is deteriorating and will continue to do so at a rapid pace. One reason for this deterioration is, in our view, that the VA is attempting to play "catch up" with respect to renovations due to what could be classified as severe under funding over a long period of time.

Mr. Chairman, this budget request simply does not go far enough to allow the VA to accomplish what it must accomplish if the system -- which represents a multi-billion dollar investment on the part of the American taxpayer -- is to remain viable.

As you are well aware, Mr. Chairman, there has been considerable concern voiced over the VA's process of prioritizing major construction projects. As a result, via the 1985 appropriation process, the VA was directed to develop a new and meaningful prioritization process (which it has accomplished).

The DAV certainly supports this concept in theory. By establishing a methodology to prioritize and give emphasis to certain kinds of projects, i.e., nursing homes, clinical, fire/safety renovations, etc., which are felt to be of relative importance over other projects, the needs of veteran beneficiaries will, in our view, be best served.

Mr. Chairman, we are pleased that the VA is attempting to develop a prototype nursing home design that can be adapted to different terrain across the country and insure uniformity, as well as reduce the cost of nursing home construction.

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However, Mr. Chairman, we are aware of a recently completed audit by the Office of Inspector General which discovered serious flaws in the development of an acceptable prototype nursing home care unit.

These flaws resulted in a conclusion that the VA has not yet accomplished its major program initiative of developing a nursing home care unit prototype that provides quality, timely and cost-effective facilities to meet the long term care needs of aging veterans.

Mr. Chairman, the DAV believes that the initiative to develop this prototype is significant and necessary. We also believe, however, that it is time for VA program officials at VA Central Office and DM&S field officials to come together and make the firm and conclusive decisions that will ultimately produce a realistic prototype nursing home care unit that can be utilized as originally conceived in theory.

Reorganization

As you know, Mr. Chairman, on October 31, 1985, then Administrator Harry N. Walters announced the agency's intention to transfer the Office of Construction into the Department of Medicine and Surgery.

The stated purpose of the reorganization was to streamline the operations of the VA's construction process by reducing functional duplication, eliminating conflicting roles and to fix accountability in one organization.

The decision to propose such a reorganization concerning the medical facility planning, design and construction program resulted from a comprehensive study -- at a cost of nearly $1

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million -- conducted by Booz, Allen and Hamilton and RTKL Associates.

As stated by the VA, the study had three goals:

* to determine, consistent with the health care mission of the VA, the most effective and efficient internal organization and procedural structures for defining, developing, designing, constructing, maintaining and improving medical and health care related capital facilities of high quality, consistent with resource and timeliness considerations;

* to assist the VA in evaluating the appropriateness, effectiveness and efficiency of its current organizational and procedural structures for the functions described above; and

* to implement, if appropriate, innovative, practical alternatives to the VA's current organization and procedures for delivering health care facility construction programs by means of fully supported recommendations for change.

In short, Mr. Chairman, the study identified major weaknesses in policies, procedures and organizational responsibilities that resulted in poor coordination between the construction and medical care programs.

The study found and recommended that a major step toward full integration between the health care program and the construction program could occur by establishing: (1) DM&S Central Office as the manager of the health care facilities construction program; (2) the Office of Construction as the provider of technical support and major construction design and construction manager; and (3) the various VA medical centers as project managers and managers for minor construction projects. Additionally, it was concluded and recommended that the consolidation of all process oversight responsibility should be placed in the Controller's office.

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Mr. Chairman, while we agree, in concept, to the need for a reorganization of the Office of Construction, we would urge the VA, in so doing, to truly streamline the process and eliminate the identified weaknesses and fragmentation while simultaneously forming a cohesive unit that will best serve the health care needs of the Veterans Administration and, ultimately, disabled veterans.

Mr. Chairman, we believe it important to point out, in our opinion, that the driving force behind the Fiscal Year 1987 construction budget -- indeed the entire VA budget -- is the Gramm/Rudman/Hollings balanced budget amendment. Not only has Gramm/Rudman/Hollings influenced the makeup of the Fiscal Year 1987 budget request, but it has also inflicted direct benefit reductions on deserving service-connected disabled veterans, their dependents and survivors in the current Fiscal Year.

We believe the VA has been short-sighted in their decisions regarding sequestering of funds in various programs -- the construction program included.

As we understand it, a 4.3% sequestering of major construction funds -- $21.8 million -- was applied across-the-board affecting 31 individual ongoing projects. While the VA states that no significant impact or slippage will occur in any individual project, we are, nonetheless, concerned that the opposite will occur.

It seems to us, Mr. Chairman, that should a sequestering of funds in the construction program be necessary in future years, the VA may more judiciously apply those provisions by withholding funds from some lesser priority projects to insure that all other projects will not suffer delay and, ultimately, cost increases to the federal government.

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Conclusion

In closing, Mr. Chairman, I want to extend the DAV's appreciation to you and the full Committee for your actions last week which added $507 million in much needed funding to the Department of Medicine and Surgery's budget.

Additionally, we commend the Committee's action in adding $23 million in construction funds for the site acquisition of the planned Palm Beach, Florida VA Medical Center, design funds for the VA Medical Center Pittsburgh (Aspinwall Division), Pennsylvania, and nursing home projects in Hampton, Virginia and Tampa, Florida. We believe these actions and the commitment the Committee has displayed toward the Veterans Administration will go a long way in maintaining the integrity and viability of the system.

Mr. Chairman, this completes my testimony and I want to again thank you for allowing us the opportunity to share our views regarding the VA's medical construction program budget request for Fiscal Year 1987.

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PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF

BOB MORAN, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

VA FY'87 CONSTRUCTION AUTHORIZATION

MARCH 6, 1986

Mr. Chairman and Members of the Subcommittee, I am Bob Moran, Associate Legislative Director of Paralyzed Veterans of America, and I am accompanied here today by Mr. Kim Beasley, Associate National Service Director with Paralyzed Veterans of America, and I want to thank you for affording us the opportunity to appear here today.

PVA appreciates the Subcommittee holding this hearing, and for being able to express our views and concerns regarding this most important issue, the VA's Fiscal Year 1987 Authorization request for construction projects.

As you know, all of PVA's members are veterans who have experienced spinal cord injury or dysfunction, and it is on behalf of these veterans who have

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considerable contact with the VA's medical facilities located throughout the United States that we present our views today.

VA Construction

PVA believes the VA's Fiscal Year 1987 proposed construction budget of $408 million in new budget authority, a reduction of over $208 million from 1986, clearly demonstrates that the Administration is continuing not to recognize (or chooses to ignore) the importance of maintaining and building adequate facilities in order for the VA to perform its assigned function.

Equally disturbing, or puzzling, is that while the VA's Office of Construction proposed Fiscal Year 1987 budget will be reduced by 34 percent from the previous year, and coupled with certain duties being taken over by another department, the construction employment level will increase by 49 FTEEs.

A newly constituted Associate Deputy Administrator for Management will now perform construction's independent facilities management and will be funded with 10 new FTEEs. In addition to all of this, an Office of Facilities, another brand new office created under a reorganization, is requesting a funding level of $38.9 million and 733 FTEEs for 1987. It is hard to understand the Administration's or VA's rationale for the significant increase in FTEEs within construction and facilities management, when a reduction in construction activity is taking place.

I would like to take this opportunity to elaborate on several critical issues regarding VA construction programs and their relationship to the recently

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completed Booz, Allen & Hamilton RTKL (BAH/RTKL) comprehensive study of the VA construction process. In a letter to Jack Powell, PVA Executive Director, dated November 1, 1985, the VA Administrator informed PVA that he had made the decision to implement the procedural recommendations of the BAH/RTKL study as "the best means to make major improvements in the timely and efficient delivery of health care construction." In addition, he announced his intention "to transfer the Office of Construction into Dm&S in order to reduce functional duplication, to eliminate conflicting roles, and to fix accountability in an organization." (Emphasis added.) In short, the purpose of the BAH/RTKL study was to streamline and correct organizational/procedural inefficiencies which would imply a reduction in FTEEs. This, coupled with the decrease in construction activity, leaves one puzzled as to the proposed increase in FTEEs.

In light of the current budgetary climate and pressures to adopt efficient operational practices, the BAH/RTKL study appears to be timely. However, it is unclear what the VA is doing to implement this study which reportedly cost $1 million. The final report recommended a number of procedural and organizational improvements which, if implemented, would significantly strengthen the construction program. The study indicates a need for:

a) A long-range strategy for meeting system-wide construction needs;

b) An efficient resource allocation methodology to meet construction needs;

c) Streamlined procedures to carry out construction projects;

d) Reduction in time required to plan and implement construction.

Furthermore, the study reveals that while sufficient numbers of staff do exist to carry out the health care facility construction process, more efficient use of staff resources can be realized.

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A common thread running through all of the study's analyses points to deficiencies in medical facility planning. The VA's annual 5 Year Medical Facility Construction Needs Assessment document submitted to Congress annually, is not an assessment of needs at all. It is simply an executive summary of major construction projects requested by each medical center every year. There is no assurance that scarce resources are being distributed where the need is most acute.

The BAH/RTKL study proposes procedural changes that would remedy this and ensure that construction dollars be allocated equitably and effectively.
The BAH/RTKL recommendations are also consistent with a statement made by Senator Alan Cranston last spring in a letter to Harry Walters: "I believe it is imperative that the VA develop an approach ... that seeks to allocate scarce funding over a greater number of projects in order to more equitably serve veterans across the nation."

We look forward to working with this Subcommittee and the VA to ensure a timely implementation of the BAH/RTKL recommendations which will result in a system that efficiently and effectively meets medical facility construction needs within budgetary restraints.

The needs of the aging veteran population will continue to place an ever growing demand on the VA's health-care delivery system, escalating an already critical situation. It is a very serious matter that so many VA facilities are now in a state of decay, only marginally meeting the needs of the veterans who use them. In previous years, testimonies given by veterans' service organizations and the Department of Medicine and Surgery indicated that over

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half of all the beds located in VA facilities are in buildings 35 years old or older. Decaying facilities not only diminish efficient patient usage, they also hamper the recruitment and retention of qualified doctors and nurses. The coming impact of the aging veteran had been a responsibility which the Veterans Administration was taking seriously. Now the VA has determined to shift its mission, by restructuring its long-term care policy, relying on the states and their communities to furnish the necessary facilities for providing care.

The VA funding to assist the states in the acquisition or construction of state nursing homes or the remodeling, modification, or alteration of existing state veterans' homes has increased to $42.4 million in 1987, up over $21.6 million from the previous year level of $20.8 million. This drastic increase in funding is somewhat unrealistic when keeping in mind the necessary planning, and restrictions that states must adhere to, not to mention the necessary funding they must secure, before such a facility can be obtained or constructed. It is apparent that more and more of the solutions to problems are being shifted to the states from the federal government. This is just one more situation evident today where the federal government is relying on the states, which are already overtaxed and overburdened, to assist in solving a critical shortage in providing for our nation's aging veterans. A task that is not rightfully theirs.

In conclusion, Mr. Chairman, PVA appreciates this opportunity to testify here today and we would be glad to respond to any questions that you might have.

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Statement of

DAVID J. PASSAMANECK

AMVETS National Legislative Director

Before The

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON HOSPITALS & HEALTH CARE

On

Veterans Administration Medical Construction

Authorization Request for Fiscal Year 1987

8:30 a.m., March 6, 1986, Room 334 CHOB

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Mr. Chairman, AMVETS is pleased to address the President's proposed Fiscal Year 1987 Budget for the Veterans Administration's medical construction authorization request.

In the summer of 1980, when President Reagan was running for the office, he inspired the veterans' community in an address to a national veterans organization convention in Boston, by promising that the earned entitlements of veterans and their dependents and survivors would not be undermined, regardless of his commitment to reducing the excesses of government spending and an ever increasing tax burden. At the same time, the President clearly set forth a basic principle of his philosophy of government, when he stated, as he did again in his State of the Union Address this year, that the most important function of government is to defend its citizens from the aggressive purposes of foreign enemies. Although the President has declared his awareness of the special status of veterans in our society, his administration has repeatedly failed to recognize that the programs established for the rehabilitation and benefit of those who have "borne the battle" are an integral and morally compelling part of the cost of national defense, as much as the cost of current military hardware. Although the defense and veterans budgetary categories are technically separate, the Veterans Administration's budget cannot be lumped together with other domestic programs not related

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to the powers and responsibilities of national defense. The President has rightfully and courageously advocated the continued recovery of our defense capability, tragically weakened in the wake of the shameful sell-out of our ally and over 58,000 of our fighting men and women in Viet Nam. However, when it comes to paying the solemn debt we owe as a nation to those who came back from that war and the World Wars and Korea as well, the special earned place of veterans is forgotten.

Almost from the inception of this Administration, the voices of fiscal conservatism, exemplified by the Grace Commission, have been calling for what amounts to the dismantling of the Veterans Administration and the essential services it provides for veterans and their families. In addition to the privatization of the finest medical delivery system in the world, the plans call for an almost total elimination of the contact, advisory, and adjudicative services upon which veterans must depend in securing those benefits which the law provides as well as elimination of all medical care for nonservice-connected veterans and eventually for those whose disabilities are not attributable to armed conflict or instrumentality of war.

AMVETS has consistently and enthusiastically supported the President's clear-headed leadership in the area of national defense. We are among the first of the veterans organizations to vigorously support the Strategic Defense Initiative, and we believe its

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increasing funding is the most vital imperative for our physical survival as a nation and for the survival of freedom in an increasingly hostile world in which we face the most ruthless, repressive and heavily armed adversary in history. We believe, as the President does, that to equate our defense requirements with the multifaceted mixture of often nonessential and unproductive government domestic spending ventures is to invite national suicide. By the same token, we refuse to accept the proposition that we can provide for an adequate national defense and at the same time betray the sacred obligations which we owe to our veterans, as well as our active and retired military personnel. Anyone who has the most superficial knowledge of military history, understands that ultimately wars are fought by people, and that if the legitimate needs of those who serve are ignored or forgotten, the most sophisticated machinery for the delivery of destruction to an enemy, or for our defense will avail us little. We are right now paying a terribly expensive price in terms of the continuous loss of trained military people to the private sector, not so much because of inadequacies of current compensation, as because of the demoralizing effect of promises and obligations to our veterans which are conveniently ignored in a misdirection of our otherwise legitimate efforts to cut the cost of goverment. So long as the President's defense policies do not include priority fulfillment of our obligations to our veterans, those policies are sadly inconsistent and to a considerable degree, self defeating.

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In order to objectively assess the perilous condition in which we find our veterans' entitlement programs as we consider the VA budget for FY 1987, we must first recognize the complete breakdown of the national budgetary process, at least as a function of intelligent, discriminating and purposeful endeavor. This past October, AMVETS responded to the initial version of the Gramm-Rudman-Hollings Amendment in letters to Senators Gramm, Rudman and Hollings by stating:

> If the Gramm-Rudman-Hollings Amendment is designed as a serious response to the economic and political realities of the budgetary quagmire, then we are in worse trouble than even the most pessimistic of us had imagined. The amendment appears to be based on two premises: That if the Congress is politically incapable of controlling spending, then the ball should be passed to the President; and that, with the exception of Social Security, all other budgetary programs are of equal value. In addition to these fundamental assumptions underlying the Amendment, subsumed in its terms is a tacit acceptance of tax increases as a possible escape from the dilemma.

AMVETS, as we have repeatedly maintained in resolutions adopted by our national conventions and testimony before Congressional committees, strongly supports those policies which seek to control

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government spending, control inflation and interest rates, and perpetuate the economic prosperity which we are now enjoying. No segment of the population suffers more acutely from economic instability than veterans and their families, many of whom are dependent on minimally sufficient disability compensation and pensions. We have seen the disastrous impact that excess government spending and its attendant deficits has had on the usually depressed employment situation of our younger veterans.

However, we specifically reject the cynical concept that all government programs, except the politically untouchable, equally deserve to be cut in order to comply with a predetermined deficit limit.

Any program to control budget deficits which ignores the essential priority of expenditures for national defense, including veterans entitlements, is completely unworkable and constitutes a dangerous threat to our very existence as a nation.

The constant actual level of expenditures for veterans' entitlements has been steadily decreasing over the past decade, while most other government programs have literally gone through the ceiling. Completely unnecessary drains on the Federal treasury, such as the Synthetic Fuels Corporation, as well as the Energy and Education Departments, the elimination of which the President

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promised to seek in 1980, go marching on, but the benefits earned by those who have made the sacrifices demanded in the defense of their country are subjected to across-the-board economizing without any accounting for comparative merit.

AMVETS believes that veterans should come first in government funding and last when budgets are cut. It is unfortunate that the Gramm-Rudman-Hollings Amendment fails to subscribe to this basic standard of civic decency.

For Fiscal Year 1987, the Administration requests a VA budget authority of $26.6 billion, which is about $408.4 million below the current estimated authority for FY 1986, notwithstanding a proposed 3.7 percent cost-of-living increase for compensation, pension and DIC, effective December 1, 1986. Under Gramm-Rudman-Hollings, compensation, pension and DIC are specifically exempt from mandatory across-the-board cuts. In addition, at least 40-percent of the nondefense items in the overall budget have been exempted from Gramm-Rudman-Hollings. Thus those nonexempt areas will be forced to shoulder an extremely disproportionate share of the cuts. The massive impact of these cuts falls on the cost of operating the Department of Medicine & Surgery and Veterans Benefits, including construction needs.

The requested authority for DM&S of a little more than $9 billion

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represents a cut of $46.1 million from 1985 levels, including more than $134 million from hospital care. More than 7,500 professionals will be cut from DM&S, including more than 1,300 nurses and more than 500 doctors, with a projected additional cut of over 15,000 by 1991. In other words, the Grace Commission will have its way, and this budget is its blueprint.

This budget proposal means a cut of 1.1 million in outpatient visits, and about 60,000 inpatients, in the face of a current turn-away rate of about 30,000 veterans a month. We are also looking at a bed level cut of 2,700, modified by the addition of about 500 nursing home beds previously approved, and by expanding existing facilities. Overall construction will be cut some $332 million, over and above the 1986 Gramm-Rudman cuts of some $21.8 million, resulting in the cancellation of seven previously planned nursing homes.

Mr. Chairman, as we look at Medical Construction, we all agree that many VA facilities are aged and in need of replacement or modernization. Focus needs to be centered on all construction projects - present and future. How can, or will, the VA respond to a veteran population which places greater annual demands on the VA for medical care? What conclusions can be drawn when the construction account is proposed at $408 million, down $368

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millions since FY 85? What will become of major and minor construction projects? How is the VA planning for the aging veterans and their related medical problems? A fresh coat of paint hides little and does little. The Replacement and Modernization account is down $188.8 million, with Nursing Home Care down an astounding $18.4 million to $4 million; even Domiciliaries is down $22.9 million with no appropriation request for FY 87.

One possible bright spot in the medical account may be the Grants for Construction of State Extended Care Facilities, proposed at $42.4 million, up $21.5 million over FY 86. Twenty Million dollars may build a lot of state veteran nursing homes which will, of course, relieve the VA of finding space for veterans in its system. We are therefore not surprised that there is a dramatic up-turn of funds in this account.

The DM&S budget seeks a massive shift of nursing home care to state and community (read private) nursing homes, even though such facilities are not available in many areas of the country. The adoption of this budget will set the entire VA medical delivery system on a rapid course to extinction, thus destroying what over 55 years of heartbreaking struggle has built into a living monument to the pride and gratitude of a free people for the sacrifices of those who shouldered arms in defense of the nation. We cannot live with this budget, or the selfish, narrow-minded,

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penny-pinching philosophy on which it is based.

This concludes my statement. I will be pleased to answer any questions regarding these matters.

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WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

HON. TIM PENNY TO VETERANS' ADMINISTRATION

Question: 1. I believe that you said, in referring to the report pursuant to the provisions of Section 202, P.L. 98-528, that 97% of all veterans are within 100 miles of a VA medical facility. In Minnesota and states to the west of us, there are many veterans for whom the distances are much greater than 100 miles. What options are you considering to better serve those veterans?

Answer: These distant areas will be given particular consideration in our future planning efforts. Unusually underserved areas will be identified at the local level through our "grass roots" Medical District Initiated Program Planning (MEDIPP) process, and then consideration will be given to the various types of alternative arrangements that can be used to meet the particular health care needs of veterans in those areas. The options include use of services in DoD or other Federal health care facilities, contracting for services with community providers, fee-based care, and VA outreach programs, such as community based clinics or traveling teams of VA staff who provide primary health care at sites within large, sparsely populated areas. The most feasible alternatives will be evaluated in terms of health care outcomes and cost-effectiveness. The VA plans to continue to develop and use innovative approaches for health care delivery in remote areas, but also to concentrate on ways to assure cost-effectiveness in existing and future outreach efforts.

Question: 2. Last year before this subcommittee and several times in the intervening months, Representative Oberstar and other members of the Minnesota delegation have discussed with the VA establishing a VA outpatient clinic in Duluth, Minnesota, an area where veterans must now travel up to 300 miles to receive VA medical care. Could you please comment on the status of that project?

Answer: On July 19, 1985, the VA approved for inclusion in the FY 1987 budget a Satellite Outpatient Clinic project for Duluth, Minnesota. This project is in the form of a funding request, in the real property rental portion of the budget, to lease facilities in Duluth in order to establish this needed outpatient clinic.

Question: 3. If subject to the authorization process, where would this rank on the VA's priority list?

Answer: Title 38, United States Code, Section 5004 requires authorization for average annual rentals of more than $500,000. The current estimate for this lease does not exceed $500,000. If refinement of the estimate should ultimately indicate that this lease will be subject to the authorization process, the establishment of an outpatient clinic in the Duluth, Minnesota area could not occur until after analysis has been completed to determine whether new construction or leasing existing space is more cost effective. Therefore, no ranking of a potential construction project can occur.

Question: 4. If authorization is not required, what is the likelihood that this project would be funded, given current budgetary constraints? How soon might this be?

Answer: The outpatient clinic project for Duluth, Minnesota, received a highly favorable evaluation in the recently completed Medical District Initiated Program Planning (MEDIPP) process, and is included in the FY 1987 budget.

Question: 5. You told us yesterday that the VA has no plans to close any VA hospitals, but that there are serious plans for "mission changes." How are you determining these mission changes and how soon will they be announced?

Answer: Analysis of the need for and the appropriateness of mission changes has occurred through the Medical District Initiated Program Planning (MEDIPP) process during the 1985 MEDIPP cycle. As part of such analysis, medical districts reviewed the current mission and activities of facilities, projected future workload, and alternate means which could continue providing veterans with quality medical care but in a more efficient, cost effective manner. Proposals developed by the medical districts were reviewed by the regions and forwarded to VACO for further review. This review is currently in progress. Announcement of any mission changes will be made when this review has been completed and the final decisions are received from the Administrator. It is expected that this process will be completed in May.

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Motto: "If I cannot speak good of my comrade, I will not speak ill of him."

DISABLED AMERICAN VETERANS

NATIONAL SERVICE and LEGISLATIVE HEADQUARTERS
807 MAINE AVENUE, S.W.
WASHINGTON, D.C. 20024
(202) 554-3501

March 26, 1986

Honorable Michael Bilirakis
House Veterans Affairs Committee
335 Cannon House Office Building
Washington, DC 20515

Dear Representative Bilirakis:

In response to your request at the March 6, 1986 Subcommittee hearing regarding the VA's medical construction budget request for Fiscal Year 1987, enclosed please find our response to the questions you posed.

Sincerely,

DAVID W. GORMAN
Assistant National Legislative Director
for Medical Affairs

DWG:cp
Enclosure

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RESPONSES OF THE DISABLED AMERICAN VETERANS
TO QUESTIONS BY THE HONORABLE MICHAEL BILIRAKIS

1. What does the DAV believe would be the most ideal mix of funding for nursing home facilities between the VA, states and the private sector?

ANSWER

The most ideal method for providing veterans with required nursing home care would be that of the VA furnishing such care directly in VA operated facilities. Pragmatically, this is not the case. Currently, the mix of providing nursing home care is distributed at 40% VA owned, 40% community and 20% state operated. The Fiscal Year 1987 budget request shifts this distribution to 30% VA, 40% community and 30% state. Reducing the VA's percentage of the average daily census of nursing home patients is not an initiative that the DAV can support. The Administration's proposed policy of shifting the responsibility of providing nursing home care to veterans in state and community facilities is further evidenced by the absence of any funding for construction of VA nursing home care facilities. At the very least, funding should be provided for sorely needed nursing home care facility construction and the current formula for providing nursing home care in VA, community and state facilities should not

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be altered as proposed in the Fiscal Year 1987 budget request. As the demand for nursing home care beds rapidly increase, we feel the VA should be directing greater attention to the conversion of acute care beds already closed (or to be closed) to nursing home care beds. In certain instances, the VA should be considering the conversion of facilities to provide for the long term care needs of veterans and, when justified, proceeding at a rapid pace to effectuate the conversion.

2. What facilities are most in need of construction funds, aside from those funded by the Committee's recommendations for Fiscal Year 1987?

ANSWER

In the opinion of the DAV, the delivery of quality health care to this nation's disabled veterans entails a commitment to modern, safe and efficient medical care facilities. To fulfill this commitment, it is necessary that the VA provide, on a continuing basis, for the reasonable expansion, renovation, modernization and replacement of its medical facilities. The VA must maintain a physical plant -- in its more than 5,000 separate buildings -- that is capable of delivering state of the art medical care, while keeping pace with modern medical advancements, as well as

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responding to the changing needs of the veteran population. As stated in DAV testimony on March 6, 1986, we support the facility planning process embodied in the Medical District Initiated Program Planning (MEDIPP) and the concept of a prioritization process for major construction projects. If fully utilized, these can serve as effective tools in the medical facility construction program and will identify the facilities most in need of construction funds. When completed, the ongoing Capital Facility Study should prove most beneficial to the VA's planning process for future construction and renovation needs. Construction funds could be put to good use by the conversion of acute care beds to long term care beds.

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The American Legion

★ WASHINGTON OFFICE ★ 1608 'K' STREET, N.W. ★ WASHINGTON, D.C. 20006 ★
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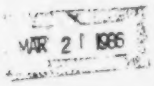
March 14, 1986



Honorable Bob Edgar, Chairman
Subcommittee on Hospitals
and Health Care
Committee on Veterans Affairs
335 Cannon House Office Building
Washington, D.C. 20515

Dear Mr. Edgar:

This is in response to the question that Congressman Michael Bilirakis asked for the record during the March 6, Subcommittee hearing on Medical Construction. The question relates to what the ideal formula, or mix of nursing beds would be in the VA, State extended care facilities, and community nursing homes.

The American Legion feels that the formula that is currently being used by the Veterans Administration consisting of 40 percent VA beds, 40 percent State Home beds, and 20 percent private sector beds has been working very well and should be continued. The new plan as contained in the Administration's VA Budget proposal for FY 1987 and the future would, as you know, change the mix to 30 percent VA, 40 percent State facility, and 30 percent community nursing home.

The proposal to place greater emphasis on the use of community facilities is not new, and The American Legion has opposed such proposals in the past, as is explained in detail in our full statement that was presented to the Subcommittee during the hearing. Briefly, community nursing homes are profit motivated, and many times veterans who require specialized care are not acceptable to these facilities because they are not profitable; and there is a lack of availability of community nursing beds in some areas of the United States because of undercconstruction and unequal distribution of long-term care resources.

Mr. Chairman, as always, we sincerely appreciate your interest in the views of The American Legion on this important issue.

Sincerely,

John F. Sommer, Jr.

JOHN F. SOMMER, JR.
Deputy Director
National Veterans Affairs and
Rehabilitation Commission

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